Benefits Guide

YOUR HEALTH MATTERS

2023

Children's National

Table Of **Contents**

What's New for **2023**?

1. Vision rates are decreasing.
2. The wait period for Children's National 100% paid parental has been removed.
3. Member savings discount program will now allow Aetna plan members to purchase certain medications not covered by their prescription plan at a discount through CVS' discount card network.
4. Fertility benefits have been expanded under all Aetna medical plans. This family planning benefit will be available to all members and has expanded coverage up to a $30,000 lifetime maximum.
5. The 2023 Health Savings Account (HSA) contribution limit will increase to $3,850 for an individual and $7,750 for a family.

Dear Employee,

We know that your life outside of work can have an impact on your ability to do your job. That's why we're dedicated to taking care of our employees by providing benefits and resources that can improve work-life balance, and help ensure that you and your family are healthy and happy.

We're proud to offer quality health care options that are affordable and accessible. We also offer additional benefits that are designed to support many aspects of your life—from health and wellness services to income protection and retirement.

This guide offers detailed information that will help you make informed decisions about your benefits. Our goal is to make the benefits enrollment experience as easy as possible for you and your family.

Please know that we are here to support you throughout the year and help you make the most of your benefits. If you have questions about how our benefits program works, please contact a member of our benefits team at 301-830-7640 or Benefits@ChildrensNational.org.

Sincerely,

Catherine Codispoti
Chief People Officer

YOUR BENEFIT CHOICES ARE IMPORTANT.

This guide will help you understand your benefit choices and help you maximize the value of your benefits package. Please take time to review this guide carefully. The more you know about your benefits, the better equipped you are to make the benefit decisions that are right for you and your family.

This benefits guide provides highlights of some of your Children's National benefit plans. This guide is not intended to provide detailed descriptions of plans. Details are contained in the official Plan documents and contracts. If there is any discrepancy between those documents and contracts and this guide, the official Plan documents and contracts will govern. Children's National reserves the right to change or terminate its benefit plans at any time and for any reason. Participation in these plans is not a guarantee of continued employment.

Your Benefit Options at a Glance

COVERAGE	PLAN OPTIONS
Medical	Bear Advantage PPO (Aetna Choice POS II network) Bear High Deductible Health Plan with Health Savings Account (Aetna Choice POS II network) Bear Select HMO (Aetna Select) Kaiser Permanente HMO
Dental	Delta Dental Plus Premier Standard Delta Dental Plus Premier Enhanced
Vision	Vision Service Plan Standard Vision Service Plan Signature
Flexible Spending Accounts (FSA)	Medical FSA: $2850 pre-tax limit Dependent Care FSA: $5000 pre-tax limit
Basic Life Insurance and Accidental Death & Dismemberment (AD&D)	Coverage based on your staff level. See page 26 for details.
Supplemental Life & Dependent Life Insurance	Employees – purchase in $10,000 increments Spouse – purchase in $5,000 increments Children – Purchase $5,000 or $10,000 Certain maximums apply. See page 26 for details.
Long-Term Disability	Coverage based on your staff level. See page 28 for details.
Retirement	401(k)
Optional Income Protection Benefits	Hospital Protection Whole Life Insurance Accident Insurance Critical Illness Plan Short-Term Disability (STD)
Optional Benefits	Legal Insurance Homeowners and Automotive insurance Pet Insurance Identity Theft Protection
Employee Assistance Program (EAP)	Confidential counseling 24-hour telephone access and web resources Free educational materials
Backup Child and Elder Care	24-hour access to emergency home-based and center-based care
Children's Discount	Discount for children of employees who receive hospital services at Children's
Commuter Benefits	SmartBenefits for Metrorail, Metro Bus and Metro Parking Stations
Fitness Centers	Global Fit discounted memberships Trinity University Fitness Center Washington Sports Clubs
Educational Assistance	Available for benefits eligible employees
Credit Union	Free checking, online banking, bill payment, and other services

Eligibility and **Enrollment** Information

ELIGIBILITY

Benefits eligibility is described as a non-temporary full-time or part-time employee regularly scheduled to work 20 or more hours per week.

You also may enroll your eligible dependents, which include your:

- Spouse or Domestic Partner;
- Dependent children under age 26; or
- Unmarried children age 26 or older who are mentally or physically disabled and rely on you for support and care

DEPENDENT DOCUMENTATION

Current and new employees who enroll newly added dependents must submit dependent documentation. Documentation for dependents of current employees who are added during open enrollment must be submitted no later than 30 days after your enrollment. Acceptable documentation includes: birth certificate, adoption agreement, marriage certificate, domestic partner affidavit, and/or court order documents. Proof of disability is required to enroll a disabled child age 26 or older.

New hires who enroll dependents must submit acceptable documentation to the Benefits Office within 30 days of hire date.

Documentation can be emailed to Benefits@ChildrensNational.org. **Failure to submit documentation within the required time frame may result in loss of coverage.**

COVERAGE LEVELS

When you enroll in medical, dental, and vision coverage, you must choose a coverage level. Coverage level choices may differ from benefit to benefit. For example, you can choose "Family" coverage for medical and "Employee Only" coverage for dental.

Children's National provides the following coverage levels to accommodate you and your family:

- Employee Only
- Employee + Spouse/Domestic Partner
- Employee + Child(ren)
- Family (employee, spouse, and children)

PAYING FOR BENEFITS

The rate sheet, posted on the Benefits Open Enrollment Intranet page, shows your costs for enrolling in medical, dental and vision plans effective January 1, 2023. After Open Enrollment season ends this information can be found on our Benefits page. For medical and dental, you and Children's National share the cost of coverage. Your benefits costs are deducted from your paycheck throughout the year on a pre-tax or after-tax basis, as follows:

- **Pre-tax contributions** are deducted from your paycheck for medical, dental, vision, flexible spending accounts, and the 401(k) plan before federal or Social Security taxes are deducted.
- **After-tax contributions** will be taken from your paycheck for supplemental life insurance and optional benefits.

SPECIAL ENROLLMENT RIGHTS UNDER CHIPRA

Employees who lose eligibility for Medicaid or CHIP or become eligible for a state premium assistance subsidy have a HIPAA special enrollment period of 60 days to enroll in a Children's National medical plan.

- Enrollment must occur within 60 days of loss of coverage or becoming eligible for the premium assistance subsidy.
- Additional information is available in the Legal Notices section of this guide.

WHEN TO ENROLL OR MAKE CHANGES

As a New Hire

You must enroll in benefits within 30 days of your hire date. The benefits you elect will become effective the first day of the month following your hire date. For example: if your hire date is March 14 and you enroll within 30 days (by April 12), your benefits will be effective April 1. Employees hired on the 1st day of the month, their benefits is effective on that day. Your premiums will be based on the April 1 effective date of your benefits. Changes made during open enrollment will be effective January 1 of the following year.

During Open Enrollment (October)

You have one opportunity each year to make changes to your medical, dental, vision benefits and to re-enroll in the flexible spending account benefits for the next calendar year. This is the annual Open Enrollment period in October. Any medical, dental, vision and flexible spending account changes made during open enrollment will be effective the following year.

WHAT HAPPENS IF I DON'T ENROLL

New Hire

You must enroll within 30 days of your hire date if you want medical, dental, vision, flexible spending accounts, short-term disability or supplemental life coverage. If you do not enroll within 30 days of your hire date, you will only be enrolled in Basic Life and AD&D, and Long-Term Disability Insurance.

DEFAULT COVERAGE IF YOU DON'T ENROLL AS A NEW HIRE

BENEFIT	IF YOU DON'T ENROLL
Medical	No coverage
Dental	No coverage
Vision	No coverage
Flexible Spending Accounts	No coverage
Basic Life and AD&D	Children's National provides coverage
Supplemental Life or Dependent Life	No coverage
Long-Term Disability	Children's National provides coverage

During Open Enrollment, you must enroll by October 28, 2022:

- If you are enrolled in a PPO or HMO plan and want to participate in the Flexible Spending Account (FSA) for the next plan year. Current FSA coverage does not roll-over to the next year.
- If you are enrolled in the High Deductible Health Plan (HDHP) and if you want to change your enrollment in any plan year for the new year you must reelect your HSA annual pledge for payroll contribution.
- If you were not enrolled in Children's National medical, dental, vision, flexible spending account, supplemental or dependent life or The Hartford short-term disability and you want to participate in one or more of these benefits for the next plan year.
- If you were not enrolled and want to enroll in optional income protection benefits such as Hospital Protection, Whole Life Insurance, Accident Insurance, Critical Illness Plan and UNUM Short-Term Disability (STD).

DEFAULT COVERAGE IF YOU DON'T MAKE CHANGES AS A CURRENT EMPLOYEE

IF YOU ARE CURRENTLY ENROLLED IN	IF YOU DON'T MAKE CHANGES BY OCTOBER 28, 2022
Medical	Your current coverage continues
Dental	Your current coverage continues
Vision	Your current coverage continues
Flexible Spending Accounts	You will not have Flexible Spending Account (FSA) coverage for 2023. **You must re-enroll in the FSA each year during open enrollment to continue contributions for the next year.**
Supplemental Life or Dependent Life	Your current coverage continues

HOW TO ENROLL OR MAKE CHANGES

The best way to enroll or make changes is online. You can access the online enrollment system from any computer with Internet access. Here are the easy steps for enrolling online.

1. From any computer connected to the Children's National network (connected on site, or through VPN or remote.cnmc.org), access Bear Resources HR: https://bearhr.cnmc.org/psp/cnmhrprd.
2. Enter your username and password.
   - Your User ID is your Network ID.
   - Your password is the same password you use to log on to the network. If you need to reset your password or you have problems logging in, please contact the Help Desk at 202-476-4357.
3. After you have completed your enrollment or made changes, be sure to confirm your elections before exiting.

MAKING CHANGES DURING THE YEAR

Outside of annual open enrollment, you may change your medical, dental, vision, flexible spending account benefits, and optional benefits **within 30 days** of experiencing one of the following qualifying life events during the year:

- Birth, legal adoption or placement for adoption of a child
- Marriage, divorce or legal separation
- Dependent child reaches age 26
- Spouse gains or loses employment or eligibility with current employer
- Death of spouse or dependent child
- Spouse or dependent becomes Medicare/Medicaid or CHIP eligible or ineligible
- Change in residence that changes eligibility for coverage
- Court-ordered change

To make changes during the year, contact the Benefits team at benefits@childrensnational.org or by phone, at 301-830-7640, within 30 days of the event. The following is a list of acceptable documentation: birth certificate, adoption agreement, marriage certificate, COBRA, divorce decree, death certificate, and/or court order documents. If you fail to make changes within 30 days of the event, you will have to wait until the next open enrollment period to make changes.

When Benefits Begin For New Hires

FOR THESE BENEFITS...	COVERAGE BEGINS
· Medical · Dental · Vision · Flexible Spending Accounts · Health Savings Account	· First of the month following your date of hire (if you enroll within the first 30 days of your employment) · For example, if your hire date is January 15, coverage begins on February 1 · If your hire date is February 1, your coverage starts on February 1
Basic Life Insurance	· 30 days after your date of hire · There is a 30-day waiting period
Supplemental Life & Dependent Life Insurance	· 30 days after your date of hire · There is a 30-day waiting period
Long-Term Disability	· Six months after your hire date
UNUM Short-Term Disability (STD) The Hartford Short-Term Disability	· First of the month following your date of hire · Approval is not automatic · Coverage begins based on approval by UNUM, the STD vendor
Retirement · 401(k)	· Contributions start on the next available pay period after you enroll · 401(k) matching employer contributions begin after one year of employment if you are contributing to the 401(k)
Optional Income Protection Benefits · Whole Life Insurance · Accident Insurance · Critical Illness Plan · UNUM Short-Term Disability (STD) · Hospital Protection	· Coverage begins on the effective date established for the enrollment period
Optional Benefits · Identity Theft · Homeowners/Automobile Insurance · Legal Insurance · Pet Insurance	· Contributions start based on your enrollment in these plans

For **Your Health**

MAKING YOUR ENROLLMENT DECISIONS

Everyone has different needs when it comes to benefits coverage, so Children's National offers you many choices. To help you decide the best health benefit option for you, use ALEX. ALEX is an interactive benefits tool that can be used to compare Children's National benefit plan options, and help you select the best benefit plan option for you.

TERMS YOU NEED TO KNOW

Copay: a fixed dollar amount that covered employees and dependents pay for certain medical services.

Coinsurance: a percentage of medical plan costs that covered employees and dependents pay after the deductible is met.

Deductible: a fixed dollar amount that covered employees and dependents pay out-of-pocket before the plan will begin paying benefits.

- Under the Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO) plans, examples of expenses that do not count toward the deductible include preventive care, office visits, and prescription drugs. Note that these expenses accumulate towards the plan out-of-pocket maximum. Under the High Deductible Health Plan (HDHP), covered employees must meet the deductible before the plan begins to pay for services other than preventive care.

In-network providers: doctors, hospitals, and other providers with whom the medical plan has an agreement to care for its members. Covered employees and dependents have lower out-of-pocket costs when using in-network providers.

Out-of-network providers: doctors, hospitals, and other providers with whom the medical plan does not have an agreement. Covered employees and dependents pay more to use out-of-network providers.

Out-of-pocket maximum: the most employees have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Pre-certification: when you need authorization from your insurance provider before specific services can be covered. Often times, this includes hospital admissions (inpatient or outpatient) or surgery. Failure to obtain pre-certification could result in a financial penalty.

ALEX BENEFITS COUNSELOR

Make the Best Decisions for You and Your Family

ALEX helps you choose the best benefits for your situation.

- ALEX makes personalized benefits recommendations by learning about your household's health care needs, and spending style.
- ALEX helps you make better, smarter benefits decisions.
- ALEX increases your understanding of benefits, making it easier for you to stay healthy and productive.

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HOW THE OPTIONS COMPARE

Your medical options are different in some important ways, such as how you access care, your cost when you seek care, and your bi-weekly premiums. Over the next few pages, we'll explain the differences in each type of plan.

MEDICAL PLAN OPTIONS

You have four medical options to select from:

PPO (1)
One Preferred Provider Organization (PPO) Plan administered by Aetna
Bear Advantage PPO (Aetna Choice POS II)

HDHP (1)
One High Deductible Health Plan administered by Aetna
Bear High Deductible Health Plan (HDHP) with Health Savings Account (HSA) (Aetna Choice POS II)

HMO (2)
Two Health Maintenance Organization (HMO) Plans
1. Bear Select HMO (Aetna Select)
2. Kaiser Permanente HMO

PRE-CERTIFICATION REQUIREMENTS[1]

Aetna medical options (PPO and High Deductible Health Plan) require that all planned hospital admissions and certain procedures be approved before they are performed. This is called pre-certification. If you have questions about pre-certification, you can contact Aetna directly at 1-888-632-3862 (for PPO-based plans). If pre-certification is not obtained, there is a $200 penalty for out-of-network inpatient confinement.

TRANSGENDER HEALTH SERVICES

All four of our medical plan options cover medically necessary health services for transgender people, including gender transition-related treatment such as hormone therapy, surgeries, and mental health services. For additional information on Transgender Health Services, please refer to your benefits summary or Summary Plan Description (SPD).

FAMILY PLANNING FERTILITY PLAN

We are pleased to announce that we have expanded our fertility benefits under all Aetna medical plans. This family planning benefit is now available to all members and has expanded coverage. All Aetna plans will cover fertility services up to a $30,000 lifetime maximum. Among the covered fertility services:

- Ovulation induction - Advanced reproductive technology - Artificial insemination - Injectable fertility drug

For additional information on our fertility benefits, please refer to your benefits summary or SPD.

ACUPUNCTURE BENEFITS

Children's currently covers acupuncture in lieu of anesthesia only. In addition, Aetna offers acupuncture for chronic pain management as a standard benefit. This provides acupuncture for up to 10 visits per year, subject to the Physician's cost share. Acupuncture in lieu of anesthesia for surgery remains unlimited.

PREFERRED PROVIDER ORGANIZATION (PPO)

A PPO gives you the freedom to choose any provider when you need care. You pay less and there are no claim forms to file when you use a provider in the PPO's network of doctors, hospitals, and other facilities. If you decide to go out-of-network, you are still covered but you pay more. Children's National has access to Aetna's national network, including over 22,000 primary care physicians and 59,000 specialists in DC area (including PA and DE) alone. This access offers you many choices when it comes to finding a network provider. There are limits on the amount you have to pay out of your pocket each year (out-of-pocket maximum) for all covered services. If you meet your out-of-pocket maximum during a calendar year, the plan pays 100% of your remaining eligible expenses.

NOTE: *This is a summary. Please see the Schedule of Benefits and Plan Booklet for detailed information.*

KEEPING YOU HEALTHY

Children's National and Aetna, our health plan administrator, have partnered to offer you a wealth of resources you can use to get and stay healthy, monitor your health and address health issues as they arise. Make sure to check out the specific health tools that Aetna provides to its members by logging in to your account at www.aetna.com .

BEAR ADVANTAGE PPO	IN-NETWORK*	OUT-OF-NETWORK*
Deductible		
Individual	$300	$600
Family	$600	$1,200
Out-of-Pocket Maximums (OOPM)		
Individual	$3,500	$7,000
Family	$7,000	$14,000
CATEGORY OF SERVICE		
Preventive Care		
Well Baby and Childcare Well Adult Care Annual Gynecological Visit Mammogram Cancer Screenings	No charge	40% coinsurance
Physician Services		
Primary Care for illness or injury	$25 copay; no deductible	40% coinsurance
Specialist	$40 copay; no deductible	40% coinsurance
Teladoc (for general medicine)	$15 copay	Not covered
Other		
Allergy Care Testing	If PCP: $25 copay If Specialist: $40 copay No deductibles	40% coinsurance
Injections		40% coinsurance
Infertility Testing		40% coinsurance
Chiropractic Care (50 visits/calendar yr)		40% coinsurance
Maternity Care		
Office Visits	No charge	40% coinsurance
Childbirth/Delivery professional services	20% coinsurance	40% coinsurance
Childbirth/Delivery facility services	20% coinsurance	40% coinsurance
Hospital/Facility Services		
Inpatient[1] or Outpatient Surgery	20% coinsurance	40% coinsurance
Emergency Room	20% after $200 copay	20% after $200 copay
ER Transportation	20% coinsurance; no deductible	20% coinsurance; no deductible
Urgent Care Center	$40 copay; no deductible	40% coinsurance
Diagnostic Tests (Lab & x-ray); $0 for Quest	20% coinsurance	40% coinsurance
Imaging (CT/PET scans/MRIs)	20% coinsurance	40% coinsurance
Habilitation/Rehabilitation Services		
Home Health (120 visits/year)[1] Rehabilitation (60 visits/year/injury) Habilitation Skilled Nursing Durable Medical Equipment (1/purpose) Hospice (60-day lifetime max inpt)[1]	20% coinsurance	40% coinsurance
Behavioral Health/Substance Abuse		
Inpatient Services[1]	20% coinsurance	40% coinsurance
Outpatient Services	$40 copay/office visit; 20% coinsurance for all other services; no deductible	
Prescription Drug (Admin by CVS/Caremark)		
Retail		
Generic	$15 copay	$15 copay
Preferred Brand	$35 copay	$35 copay
Non-Preferred Brand	80% coinsurance up to OOPM	80% coinsurance up to OOPM
Specialty (CVS/Caremark Specialty Pharm only)	20% coinsurance up to $150 max	Not covered
Mail Order		
Generic	$30 copay	Retail only
Preferred Brand	$70 copay	Retail only
Non-Preferred Brand	80% coinsurance up to OOPM	Retail only
Specialty (CVS/Caremark Specialty Pharm only)	20% coinsurance up to $150 max	Not covered
Vision Care		
Children's eye exam (1 exam/12 months)	$40 copay/visit; no deductible	Not covered
Children's glasses	No coverage	
Adult eye exam (1 exam/12 months)	$40 copay/visit; no deductible	

** Unless otherwise noted, the applicable deductible must be met before the coinsurance applies. Out-of-network subject to allowable benefit.*

[1] Pre-certification required for inpatient confinements to avoid $200 penalty.

HIGH DEDUCTIBLE HEALTH PLAN WITH HEALTH SAVINGS ACCOUNT (HSA)

The Bear High Deductible Health Plan with Health Savings Account (HSA) uses a national network of providers, just like the PPO plan, but the way you pay for your care and prescription drugs is different. **You must meet a deductible before the Plan begins to pay for services other than preventive care.** In addition, the cost of participating in this plan (your payroll contribution) is significantly lower than the cost for other health coverage offered by Children's National.

The Bear High Deductible Health Plan includes four components:

- 100% coverage for preventive care in-network
- Deductible for all other services
- Plan coverage (in- and out-of-network)
- Health Savings Account (HSA)

Let's look at the features of the plan more closely:

Preventive Care – When you use an in-network provider, your preventive care services, such as annual physicals, well childcare, annual gynecological visits, and wellness screenings are covered in full. No deductible applies.

Deductible – You must meet a deductible before the plan begins to pay for covered services other than preventive care. This includes office visits, hospital stays, and prescription drugs. The deductible is significantly higher than the deductible for the PPO Option.

You can pay your deductible from your own pocket, or you can decide to use funds from your Health Savings Account (HSA).

Plan Coverage – Once you meet the deductible, the plan pays for covered services. Most services received in-network are covered at 90% and out-of-network services are covered at 70% of reasonable and customary amounts.

Health Savings Account (HSA) – If you elect the High Deductible Health Plan, you have the option of opening an HSA with your own pre-tax contributions. You can use your HSA to pay your qualified out-of-pocket health care expenses. It is a good idea to save at least an amount equal to your deductible. You must re-elect your payroll contribution for the HSA each year during open enrollment to fund your account for the upcoming year.

BENEFITS OF AN HSA

- It's a type of savings account permitted under current tax law.
- Money you contribute to this account will be automatically deducted from your pay on a pre-tax basis each pay period.
- The money in your account can grow with investment earnings on a tax-free basis.
- Unlike the flexible spending accounts, any money you have left in the account at the end of the year can be rolled over to the next year and there is no deadline to receive reimbursement for health care expenses.
- You can roll the money over to a new health savings account or take the money with you if you leave Children's National.
- You can use the money you have saved over time to help pay for any health care expenses, whenever you need it. You won't have to pay taxes on any of the money you withdraw if you use it for qualified health care expenses.

IS THE HIGH DEDUCTIBLE HEALTH PLAN RIGHT FOR YOU?

The HDHP is the right fit for a wide variety of employees. The way the plan works is a little different than the PPO or HMO plan so employees selecting this plan should understand how it works and how it can coordinate with the HSA (if eligible). Note that the HDHP plan has the lowest paycheck contribution but might result in incurring more costs at point of service due to the high deductible. This might result in you spending more time identifying services that are the best for you, at the most reasonable cost. Since there is a tax savings element to this plan, it is recommended that you save all bills, explanation of benefits (EOB) forms or other documentation to support your use of your HSA funds. The decision is yours.

Log on to www.aetna.com/hsa/videopre for useful information in determining if an HDHP with HSA is right for you!

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BEAR HIGH DEDUCTIBLE HEALTH PLAN W/ HEALTH SAVINGS ACCOUNT (AETNA CHOICE POS II)

BEAR HIGH DEDUCTIBLE HEALTH PLAN W/HSA	IN-NETWORK*	OUT-OF-NETWORK*
Deductible		
Individual	$1,500	$3,000
Individual + 1	$2,800	$5,200
Family	$3,000	$6,000
Out-of-Pocket Maximums (OOPM)		
Individual	$3,000	$6,000
Individual + 1	$5,200	$10,400
Family	$6,000	$12,000
CATEGORY OF SERVICE		
Preventive Care		
Well Baby and Childcare Well Adult Care Annual Gynecological Visit Mammogram Cancer Screenings	No charge	30% coinsurance after deductible
Physician Services		
Primary Care for illness or injury	10% coinsurance after deductible	30% coinsurance after deductible
Specialist	10% coinsurance after deductible	30% coinsurance after deductible
Teladoc (for general medicine)	$49/copay	Not covered
Other		
Allergy Care Testing Injections Infertility Testing Chiropractic Care (50 visits/calendar yr)	10% coinsurance after deductible	30% coinsurance after deductible
Maternity Care		
Office Visits	No charge	30% coinsurance after deductible
Childbirth/Delivery professional services	10% coinsurance after deductible	30% coinsurance after deductible
Childbirth/Delivery facility services	10% coinsurance after deductible	30% coinsurance after deductible
Hospital/Facility Services		
Inpatient[1] or Outpatient Surgery	10% coinsurance after deductible	30% coinsurance after deductible
Emergency Room		10% coinsurance after deductible
Emergency Room Transportation		10% coinsurance after deductible
Urgent Care Center		30% coinsurance after deductible
Diagnostic Tests (Lab & x-ray); $0 for Quest		30% coinsurance after deductible
Imaging (CT/PET scans/MRIs)		30% coinsurance after deductible
Habilitation/Rehabilitation Services		
Home Health (120 visits/year)[1] Rehabilitation (60 visits per year/injury) Habilitation Skilled Nursing Durable Medical Equipment (1/purpose) Hospice (60-day lifetime max inpt)[1]	10% coinsurance after deductible	30% coinsurance after deductible
Behavioral Health/Substance Abuse		
Inpatient Services[1]	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient Services		
Prescription Drug (Admin by CVS/Caremark)	**Must satisfy deductible before copay applies**	**Must satisfy deductible before copay applies**
Retail		
Generic	$15 copay	$15 copay
Preferred Brand	$35 copay	$35 copay
Non-Preferred Brand	80% coinsurance up to OOPM	80% coinsurance up to OOPM
Specialty (CVS/Caremark Specialty Pharm only)	20% coinsurance up to of $150 max	Not covered
Mail Order		
Generic	$30 copay	Retail only
Preferred Brand	$70 copay	Retail only
Non-Preferred Brand	80% coinsurance up to OOPM	Retail only
Specialty (CVS/Caremark Specialty Pharm only)	20% coinsurance up to of $150 max	Not covered
Vision Care		
Children's eye exam (1 exam/12 months)	No charge	Not covered
Children's glasses	Not covered	
Adult eye exam (1 exam/12 months)	No charge	

** Unless otherwise noted, the applicable deductible must be met before the coinsurance applies. Out-of-network subject to allowable benefit.*

[1] Pre-certification required for inpatient confinements to avoid $200 penalty.

HSA ENROLLMENT

You may only contribute to an HSA if you are enrolled in the High Deductible Health Plan. When you enroll, you can elect the HSA and the amount you want to contribute. Your contributions will be deducted from your pay in equal installments over the course of the year, tax-free.

For 2023, the IRS maximum annual HSA contributions are:

Employee Only coverage	$3,850
Family coverage	$7,750
Catch Up Contributions* addt'l	$1,000

**for participants who are age 55 or older*

Notice of Potential for Improper HSA Contributions

Determination of eligibility to contribute to the Health Savings Account (HSA) is the responsibility of the participant. You are strongly encouraged to consult your tax advisor if you have eligibility questions as improper deductions can create tax consequences.

To be an eligible individual and qualify to contribute to an HSA, you must meet the following requirements:

1. You are covered under a high deductible health plan (HDHP).
2. You have not received medical benefits through the Department of Veterans Affairs (VA) for non-service related conditions, other than allowable preventive care, dental or vision benefits, in the last three months.
3. You or your spouse are not enrolled a general purpose Health Care Flexible Spending Account from which your eligible medical expenses can be reimbursed.[1]
4. You cannot be claimed as a dependent on someone else's tax return.[2]
5. You are not enrolled in Medicare.[3]

For more information, you may refer to IRS Publications 969 and 502 for a complete list of eligibility rules and details about limits and eligible expenses.

[1] *A general purpose FSA provides reimbursement for medical expenses (and possibly for other expenses such as dental or vision), as compared to a Limited Flexible Spending Account which, does not reimburse medical expenses. You or your spouse's participation in a LFSA (for eligible dental/vision reimbursement) does not make you ineligible to participate in an HSA.*

[2] *Health Care Reform has made it possible for parents to keep dependents up to age 26 on their health plan. The IRS tax law did not change the definition of a dependent. You may have adult dependent children covered under your health plan who are not dependents for tax purposes. HSA funds can only be spent on family members who qualify as true tax dependents.*

[3] *For Medicare and HSAs, there are a few restrictions. When an HSA owner's Medicare coverage begins, that individual can no longer contribute to the HSA. Bear in mind, though, the HSA balance is available for other out-of-pocket medical expenses.*

LIMITED FLEXIBLE SPENDING ACCOUNT (LFSA)

Limited Flexible Spending Accounts (LFSA) are pre-tax spending accounts that can be elected annually for vision and dental expenses. They work very similarly to the Medical FSA.

HDHP participants with HSA accounts can elect LFSA accounts. The LFSA account can be used in addition to participant's HSA funds to pay for eligible out of pocket dental and vision expenses.

Many of us overlook the added advantages of contributing to a Limited FSA in conjunction with an HSA.

There are a few principal reasons a person should contribute to both a LFSA and an HSA in order to get the most out of their HSA.

1. You plan on incurring eligible dental or vision expenses early in the plan year

FSAs (including Limited FSAs) have been designed so that your full election is available on day 1 of the plan year. HSA funds are only available as the funds are deposited into your account. Because of that, if you are planning on incurring dental or vision expenses early in the plan year, a LFSA is a great way to plan to pay for those expenses.

2. You want to save your HSA contributions for future medical expenses

Dental and vision expenses are usually easier to predict than medical expenses. When you are covered by a High Deductible Health Plan (HDHP) and you know you may be required to pay higher amounts for the medical expenses you incur it especially makes sense to contribute towards your LFSA for dental and vision expenses that you plan on incurring. That way you can preserve HSA contributions to be used for medical expenses.

WHAT IS TELADOC?

Teladoc is the first and largest provider of telehealth medical consults in the United States, giving members 24/7/365 access to quality care through phone and video medical and behavioral health consults.

WHO ARE THE TELADOC DOCTORS?

Teladoc doctors are U.S. board certified in Internal Medicine, Family Practice, Emergency Medicine, or Pediatrics. They average 15 years of practice experience, and are licensed in the state where the patient is physically located at the time of consult.

DO TELADOC PHYSICIANS TREAT BOTH ADULTS AND CHILDREN?

Yes. Teladoc provides quality care for members of any age.

HOW DO I SET UP MY TELADOC ACCOUNT?

Setting up your account is a quick and easy process online. Visit www.teladoc.com and click "Set Up Account". Follow the online instructions. You can also call Teladoc directly at 1-855-TELADOC to set up your account.

TELADOC™

TELADOC

Teladoc gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It is an added benefit that gives you an affordable alternative to more costly provider service settings such as an urgent care or Emergency Room visit. It does not replace your primary care provider but it gives you a convenient and less expensive option for quality care. We recommend pre-registering at www.teladoc.com/MyTeladoc or call 1-855-Teladoc (835-2362), before using Teladoc.

Some general medical conditions Teladoc can treat include:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infections
- Respiratory infections
- Sinus problems

Teladoc general medicine copay is $15 for both the PPO and HMO. A $49 consultation fee is required for the HDHP, until deductible is met, then subject to coinsurance. The Teladoc fee for dermatology consults is $75.

Teladoc also has behavioral services available. They can help you with:

- Stress
- Anxiety
- Sadness
- Family issues
- Relationship problems
- Grief

For those with the HDHP, the Teladoc behavioral health consult fees are as follows:
An initial psychiatry (MD) visit will be **$190**; all subsequent psychiatry visits will be **$95**.
All therapy (non-MD) visits will be **$85**.

3. Your medical expenses are high enough that you will use the full HSA contribution limit to pay for your medical expenses each year

If you know your medical expenses are going to meet or exceed the annual contribution limit for your HSA and you plan on incurring dental and vision expenses as well, using your LFSA is a great way to maximize your tax savings.

4. You wish to use your HSA as a primary/additional retirement or investment account or to cover health-related costs in retirement

HSAs are often explained as providing a triple-tax advantage. That means you get a tax advantage on your contributions towards your HSA, your distributions from your HSA (if used for eligible expenses), and any interest you earn from your HSA. By using your LFSA for dental and vision expenses you can get the most of the triple-tax advantage available with your HSA.

Although each person's situation is unique, there are many situations where it makes sense to contribute to both your HSA and LFSA. It may take some planning but will pay off if you plan correctly.

Sandall, Steve. "Using a Limited FSA in Conjunction with your HSA." National Benefit Services. https://www.nbsbenefits.com/. 22 February 2016.

DOCFIND – AETNA'S ONLINE PROVIDER DIRECTORY

Find Aetna health care professionals that accept your plan:

- **You could end up paying a lot more** if you use a health care professional that does not accept your plan or does not provide the highest level of coverage under your plan.
- The most current information on doctors and facilities that participate in the Aetna PPO and Aetna Select network can be found on Aetna's DocFind online directory. DocFind also shows medical schools attended, board certification status, and languages spoken by each network doctor.
- To find a network doctor: Go to www.aetna.com and click on "Find a Doctor," and then search by zip code, city, state or country.

FOR THIS PLAN:	ON DOCFIND SELECT:
Bear Advantage PPO	"Aetna Open Access® Plans" – Aetna Choice POS II (Open Access)
Bear HDHP with HSA	"Aetna Open Access® Plans" – Aetna Choice® POS II (Open Access)
Bear Select HMO	"Aetna Standard Plans" – Aetna Select

BENEFITS OF USING AN IN-NETWORK PROVIDER

As a PPO or High Deductible Health Plan participant, the best way to manage your health care costs is to use in-network providers. With in-network providers, you pay less and there are no claim forms to file. Aetna's in-network providers can be located online using DocFind. Kaiser providers can be located on the Kaiser Permanente website.

AETNA MOBILE

Life takes you on the go. Now your health information can follow. Use your cellphone with web access to view your health plan information. The Aetna Mobile app works with iPhone® mobile digital devices and Android™ powered phones. Use a different Smartphone or mobile device? Instead of loading an app, just visit www.aetna.com and use the mobile web version of the site.

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

With an HMO, all care must be received from doctors and hospitals who participate in that HMO network. If you receive care from a provider who does not belong to the HMO, it's not covered. There is one exception – emergency care. Coverage for the use of non-HMO providers is limited to a medical emergency. In addition, you must select a primary care physician within the HMO who is responsible for managing all of your care. **You may select a separate primary care physician for yourself and each of your covered dependents.**

With an HMO, there are no claim forms to complete.

HMO coverage includes:

- No deductible
- Most other services, including office visits and prescription drugs covered in full after a copayment
- An annual out-of-pocket maximum limit on the amount you have to pay for covered services for the calendar year

AETNA MEMBER WEBSITE

Aetna Member Website is Aetna's online tool to help you manage your health care online, anytime and from anywhere that you have computer access. This site allows you to check for participating doctors and facilities, check claim status, order a new ID card, research hospital outcomes, price medical procedures, and more!

HMO BENEFITS AT A GLANCE	AETNA BEAR SELECT	KAISER PERMANENTE
Deductible	None	None
Out-of-Pocket Maximums (OOPM)		
Individual	$2,750	$2,250
Family	$6,500	$4,500
CATEGORY OF SERVICE		
Preventive Care		
Well Baby and Childcare Well Adult Care Annual Gynecological Visit Routine Cancer Screenings (Mammogram, PAP smears, PSA, colonoscopy)	No charge	No charge
Physician Services		
Primary Care for illness or injury	$20 copay	$20 copay (Waived for child under age 5)
Specialist (with referrals/prior approvals)	$20 copay	$20 copay
Telemedicine (for general medicine)	$15 copay	No charge
Other		
Allergy Care Testing	$20 copay	Cost based on type and place of service
Injections	No charge	Cost based on type and place of service
Maternity Care		
Initial Office Visit	No charge	No charge
Childbirth/Delivery professional services	No charge	No charge
Childbirth/Delivery facility services	$500/admission	$500/admission
Hospital/Facility Services		
Inpatient	$500 copay/admission	$500 copay/admission
Outpatient Surgery	$250 copay	$250 copay
Emergency Room	10% coinsurance after $200 copay	$200 copay
ER Transportation	No charge	$100 copay
Urgent Care Center	$50 copay	$20 copay
Diagnostic Tests (Lab & x-ray)	No charge	No charge
Imaging (CT/PET scans, MRIs)	No charge	$50/test
Habilitation/Rehabilitation Services		
Home Health	No charge	No charge
Rehabilitation	$20 copay	$20 copay
Habilitation	$20 copay	$20 copay
Skilled Nursing	$250 copay/stay	$500 copay/admission
Durable Medical Equipment	No charge	No charge
Hospice	$500 copay/inpatient admission; $30 copay/outpatient visit	No charge
Behavioral Health/Substance Abuse		
Inpatient Services	$500 copay/admission	$500 copay/admission
Outpatient Services (No referral necessary)	$20 copay/visit; other outpatient services: no charge	$20 copay individual/$10 copay group
Prescription Drug Coverage		
Retail	Retail @ CVS/Caremark	Retail @ Kaiser Pharmacy
Generic	$15 copay	$15 copay; $25 at Participating Pharm
Preferred Brand	$35 copay	$25 copay; $40 at Participating Pharm
Non-Preferred Brand	80% coinsurance up to OOPM	$40 copay; $55 at Participating Pharm
Specialty (max copay/30 day supply)	20% coinsurance up to of $150 max	50% coinsurance up to $100 max
Mail Order		
Generic	$30 copay	$15 copay; $25 at Participating Pharm
Preferred Brand	$70 copay	$25 copay; $40 at Participating Pharm
Non-Preferred Brand	80% coinsurance up to OOPM	$40 copay; $55 at Participating Pharm
Specialty (max copay per 30 day supply)	20% coinsurance up to of $150 max	50% coinsurance up to $100 max
Vision Care		
Children's eye exam	$20 copay/visit (1 exam/24 mos.)	$20 copay/visit
Children's glasses	Not covered	No charge
Adult eye exam	$20 copay/visit (1 exam/24 mos.)	$20 copay/visit
Out-of Network Coverage	No out-of-network coverage	No out-of-network coverage

For Your **Mental Health**

RESOURCES FOR ALL EMPLOYEES

24/7 support for all life's challenges

SupportLinc, your Employee Assistance Program (EAP), is a confidential resource that helps you deal with life's challenges and the demands that come with balancing home and work. For greater details, please see page 33.

In addition to the Employee Assistance Program and our LiveWell Wellness Program, you have many resources available to you as an employee.

Emotional support and workshops from Chaplaincy Services

A variety of resources are available, including:

- **Comfort Corner:** A television is set up on a unit and plays pictures, videos and music to help staff take a break.
- **Mindfulness Training:** These 40-minute workshops focus on resilience and mindfulness techniques.
- **Resilience Rounds:** A chaplain with a behavioral health background provides a listening ear for an hour to help you process your emotions and workplace stresses.
- **CALM Staff Support and Crisis Intervention Program**: A psychosocial mental health facilitator can provide support in person or online. To learn more or schedule any of these services, contact a chaplain at 202-476-3321.

RESOURCES FOR EMPLOYEES WITH AN AETNA® MEDICAL PLAN

Aetna medical plans cover more than just physical well-being. There's also help and support for a healthier state of mind, with:

Coverage for individual, group and family therapy

Get help for anxiety/depression, stress, family issues, grief and loss, and more. Visit a therapist, counselor or other network mental health provider in person or by phone or video, if they offer virtual visits.
Find a provider: Log in at **Aetna.com > Find Care & Pricing**

Access to therapy, anywhere in the U.S.

In addition to nonemergency medical care, Teladoc® is available for therapy and counseling. Aetna members age 16+ can connect with a psychiatrist, psychologist, social worker or therapist by phone or video. Talk confidentially from the comfort of home, or anywhere. **Get started:** Visit **Teladoc.com/Aetna**, call **1-800-835-2362**, or download the Teladoc app on your smartphone or tablet.

Support for big changes

Some life events can be overwhelming, like having a baby, or finding out you have diabetes or heart disease. AbleTo is a free eight-week program that connects you with two specialists each week, a therapist and a behavior coach. They'll help you:

- Work through emotions
- Identify changes you may need to make
- Understand your treatment plan
- Feel more in control of your health and life

Get started: Call **1-844-330-3648** or download the AbleTo app to answer some questions and see if you qualify.

RESOURCES FOR EMPLOYEES WITH KAISER PERMANENTE MEDICAL PLAN

Your mind, body and spirit and all connected. That's why to help you achieve and maintain optimal mental, physical and emotional health, Kaiser Permanente offers:

Beyond therapy, medication, and treatment
Access classes and tools that can help keep your mind, body, and spirit in healthy balance. Check out our online classes (some may require a fee) and communities, self-assessment tools, personalized plans, support groups, and podcasts.

Care at your convenience
Plan care around your life:
- See a therapist without a referral
- Schedule a video visit
- Call your doctor's office
- Get care advice 24/7
- Seek emergency care

For more information on these or other services, **visit kp.org/selfcare**.

RESOURCES FOR EMPLOYEES WITH EITHER AETNA OR KAISER

myStrength offers personalized programs with interactive activities, daily health trackers to monitor and maintain your progress, in-the-moment coping tools, and more. It's designed to help you set goals and work towards them in ways that work for you – by making positive changes that support your mental, emotional, and overall well-being.

Aetna members can access myStrength by
- Text at "GO CNH" to 85240
- Phone at **1-800-945-4355** registration code: CNH
- Online at **Ready.livongo.com/CNH/register**

Adult Kaiser members can download popular apps at kp.org/selfcareapps

For more information, check out our Lifestyle Benefits on page 19.

PRESCRIPTION DRUGS

Prescription drug coverage is provided automatically with all medical options. Under all Aetna medical options, prescription benefits will be managed by CVS/Caremark and must be filled at a network pharmacy or through CVS/Caremark's mail order program. For High Deductible Health Plan participants, the copay applies after the deductible is met. Under Kaiser Permanente, prescription drugs must be filled at a Kaiser Community pharmacy or through the Kaiser mail order program.

IMPORTANT REMINDER ABOUT YOUR MAINTENANCE MEDICINE

Once you fill a 30-day supply at any network pharmacy, you may only receive up to two refills. After that, you refills will be filled on a 90-day supply only.

PRESCRIPTION DRUG TERMS TO KNOW

Copayments for prescription drugs under all medical options are based on a formulary (an approved list of drugs). There are four tiers of drugs – generic, preferred brand, non-preferred brand and specialty.

Tier 1	**Generic**	A drug that has the same active ingredients as the brand-name medication Generic drugs generally have the lowest copay.
Tier 2	**Preferred Brand**	A brand-named drug under your plan that has been approved and/or recommended on the basis of a clinical review. In other words, the drug is on your plan's formulary list. Preferred brand drugs are usually at a lower copay than non-preferred brands.
Tier 3	**Non-preferred Brand**	A brand-named drug that has been determined to have a clinically equivalent alternative drug available on the formulary list. Non-preferred drugs are the highest cost option under your plan.
Tier 4	**Specialty***	A drug that helps patients with complex conditions.
Maintenance (long-term) medication		Medication that is taken regularly for a chronic condition such as high blood pressure, diabetes, or high cholesterol.

**For more information on Aetna specialty drugs, visit www.caremark.com or call 1-877-232-8129.*
**For more information on Kaiser specialty drugs, visit www.kp.org/formulary.*

GENERIC SUBSTITUTION

If your physician prescribes, or you request your physician to prescribe, a brand name drug when a generic is available you will pay a higher cost. In this situation, your physician generally writes the prescription using a "dispense as written" (DAW) statement. In this case, the pharmacist can't substitute a generic drug. Because the physician's note doesn't allow for a generic substitution, your costs are higher.

GENERIC COPAY INCENTIVE

If you are taking a brand medication that has a generic option available, you can get up to six free refills when you make the change to the generic prescription medication. You can talk to your doctor or pharmacist to see if any generic options would work for you.

MAINTANENCE MEDICATION

With CVS/Caremark Maintenance Choice program, medications you take regularly such as diabetes, asthma or high blood pressure medications can be filled in 90 days supplies through CVS/Caremark Mail Service Pharmacy.

- You can choose pickup or Rx delivery by mail – either way, the cost is the same
- 90-day supplies are more convenient and usually cost less
- If you fill prescriptions for medications taken regularly at any other pharmacy, or in 30 day supplies, you will pay more.

PREVENTIVE DRUG LIST

For some medications, **you pay $0** even if you or your family haven't met your annual deductible.

The Preventive Drug List includes:

- Certain medications, supplements or products to:
  a) prevent certain health conditions;
  b) help you quit smoking and using tobacco; or
  c) prepare for certain health screenings in adults
- Vaccines and immunizations
- Contraceptives for women

Find the full list at Caremark.com.

RESOURCES FOR LIVING

24-Hour Nurse Line

Did you know you have access to a nurse 24 hours a day and seven days a week? Nurses are available to help you with your medical needs anytime, day or night. Just call the Aetna Nurseline at 1-800-556-1555.

Disease Management Programs

If you have a chronic disease, chances are the Aetna Health Connections disease management program can help you better manage your condition. Aetna Health Connections offers support for 35 common medical conditions, such as congestive heart failure, diabetes, hypertension, asthma, COPD, and cancer. You can request program enrollment by calling 1-866-269-4500 or through the Aetna Navigator website at www.aetna.com. In certain cases, a caseworker may contact you based on your medical and pharmacy claims data. The program offers information on your condition, a review of your treatment plan, and access to a 24-hour toll-free disease management phone number.

Discount Programs

As an Aetna member, you have access to discounts on fitness club memberships, treadmills, elliptical trainers, LASIK surgery, massage therapy, colored contact lenses, and more. Participating vision discount providers include Sears Optical, Target Optical, JC Penney Optical, LensCrafters, and Pearle Vision. Through the Aetna Natural Products and Services Program, you can save on services not typically covered by insurance, such as acupuncture, chiropractic care, dietetic counseling, and natural products such as vitamins and health supplements. You also receive a discount for participation in the Jenny Craig weight loss program. For additional information, go to www.aetna.com.

To download your free Aetna mobile app, text Apps to 44040 to download. Standard text messaging rates may apply.

LIFESTYLE BENEFITS

Behavioral Health

myStrength

We are excited to bring you myStrength, Livongo Behavioral Health for support with stress, sleep, anxiety, and much more! Here's what you get when you join:

A Completely Personalized Program: Take a short quiz, and get a fully customized program that's tailored to your needs and goals.

Helpful Tools and Resources: Learn practical tips and techniques with hundreds of quick activities.

Get 24/7 access to the myStrength app and web platform. Track mood, sleep, stress, goals, and more.

One-on-One Support: Get guidance from a dedicated coach. Set goals, discover helpful resources, and stay motivated and accountable.

Visit go.livongo.com to enroll.

For questions about this program, please visit the Livongo website or call Livongo Member Support at (800) 945-4355.

SPECIFIC RESOURCES FOR LIVING

As an Aetna member, you have access to the following resources designed to help you live well:

- 24-Hour Nurse Line
- Aetna Health Connections Disease Management
- Discounts for healthy living programs and services
- And much more!

LiveWell

BECOMING A BETTER YOU WITH LIVEWELL

LiveWell is a comprehensive employee wellness program that focuses on health awareness by offering food and exercise tracking, group exercise registration and opportunities to talk to a dietician while keeping employees engaged with various challenges. LiveWell aims to create and maintain awareness by offering biometric screenings, health assessments and seminars on mindfulness and resilience. You can earn up to $200 by taking steps to "Become a Better You."

For more information, visit the staff wellness intranet page or email livewell@childrensnational.org.

Health/Weight Management

Balance - Free for Kaiser health plan members!

Balance is a complimentary, personalized online program designed to help you reach your ideal weight. This program can help you get motivated, gain confidence, and overcome weight challenges. It offers resources such as videos, goal-tracking tools, recipes, and more. And it helps you address issues that may be holding you back such as weight-related psychological and emotional issues, good exercise habits, and managing food wants and needs.

To get started, go to kp.org/balance.

Weight Watchers - Special pricing

Weight Watchers offers multi-dimensional ways to learn how to achieve and then maintain a healthy body weight for the long term. The program incorporates healthful eating, physical activity, behavior modification, and in our meetings, a supportive atmosphere. Children's National Hospital has teamed up with Weight Watchers to bring effective weight management offerings at a special price.

Visit wellness.weightwatchers.com. Enter Employer ID: 10936877 and Employer Passcode: WW10936877 to sign up today!

Diabetes Management

Livongo - Free for Aetna health plan members!

The Livongo for Diabetes program is designed to support you in your diabetes management. You and your family members with diabetes can join at no cost if you have medical coverage through the Aetna medical plan. Through the Livongo program, you get:

Connected Meter: Automatically uploads your blood glucose readings to your secure online account and provides real-time personalized tips.

Support from Coaches When You Need It: Communicate with a coach anytime about diabetes questions on nutrition or lifestyle changes.

Unlimited Strips at No Cost: When you are about to run out, we ship more supplies, right to your door.

Visit welcome.livongo.com/CNMC to learn more about Livongo and enroll.

Care for Diabetes- Free for Kaiser health plan members!

Care for Diabetes can help you lead a healthier, more active life. This complimentary online program is customized to your daily routine and general health, giving you ways to manage diabetes more effectively. You'll also receive follow-up emails to track your progress.

To get started, go to kp.org/carefordiabetes.

Hypertension Management

Livongo - Free for Aetna health plan members!

The Livongo for Hypertension program makes living with high blood pressure easier by providing you with an exclusive connected blood pressure cuff, a mobile app to view and track all of your readings, and personalized health coaching. You and your family members with hypertension can join at no cost if you have medical coverage through the Aetna medical plan. Through the Livongo program, you get:

Connected Blood Pressure Monitor: Automatically sends your readings to a user-friendly app. No writing necessary!

Tips to Help You Stay on Track: Receive useful information that will help you manage your blood sugar and blood pressure and feel your best.

Coaching When You Need It Most: Our Livongo coaches support you in your journey to better health. Communicate with a Livongo coach anytime to answer your questions, receive support on your weight loss journey and advice on health improvement.

Vision

VISION SERVICE PLAN (VSP)

With VSP, you have coverage for eye exams, prescription glasses, and contact lenses. You also are eligible for discounts on laser vision corrective surgery. The plan is built around a network of vision care providers, with higher benefits when you use providers who belong to the VSP network. If you see an out-of-network provider, you must pay out-of-pocket and file a claim for reimbursement. To locate a VSP provider, go to **www.vsp.com**, go to "Find a VSP Doctor," then if prompted to select doctor network, select VSP Signature or call 1-800-877-7195.

The chart below shows coverage amounts for both VSP plans. Note that benefits for eye exams and prescription lenses are covered once a year.

VISION BENEFITS AT A GLANCE	VSP STANDARD PLAN	VSP SIGNATURE PLAN	NON VSP PROVIDER
Well Vision Exam (Once every 12 mos.)			
	$10 copay	$10 copay	Up to $52 allowance
Prescription Glasses			
Frame combined with exam	$150 allowance every 12 months $170 allowance for featured brands 20% discount on the amount over allowance	$150 allowance every 12 months $170 allowance for featured brands 20% discount on the amount over allowance	Up to $70 allowance Up to $70 allowance Up to $70 allowance
Lenses combined with exam			
Single vision	Covered in full every 12 months	Covered in full every 12 months	Up to $55.00 allowance
Bifocal	Covered in full every 12 months	Covered in full every 12 months	Up to $75.00 allowance
Trifocal	Covered in full every 12 months	Covered in full every 12 months	Up to $100.00 allowance
Lenticular	Covered in full every 12 months	Covered in full every 12 months	Up to $125 allowance
Lens Enhancements			
Tints/Photochromic adaptive Standard progressive Premium progressive Custom progressive	$0 $50 $80 - $90 $120 - $160	$0 $50 $80 - $90 $120 - $160	Up to $5.00
Contacts instead of glasses (fitting and evaluation)			
Medically Necessary Elective	Professional fees and materials Covered in full; $130 allowance; after maximum $60 copay	Professional fees and materials Covered in full; $130 allowance; after maximum $60 copay	Professional fees and services; Up to $210.00 allowance; Up to $105 allowance
Additional Pairs of Eyewear			
Frame and Lenses Contacts (instead of glasses)	Discount only Discount only	$10 copay; $150 allowance $60 copay; $130 allowance	N/A
VSP Diabetic Eyecare Plus Program (as needed)			
Services related to diabetic eye disease, glaucoma, and age related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20 copay	$20 copay	N/A

Dental

DENTAL PLAN OPTIONS

You have two dental options:

- Delta Dental PPO plus Premier Standard Plan
- Delta Dental PPO plus Premier Enhanced Plan

Dental options cover:

- Preventive Care – such as exams, routine x-rays, and cleanings
- Basic Care – such as fillings, simple extractions, endodontics, and periodontics
- Major Care – such as crowns, bridges, dentures, inlays, and onlays

NEED ORTHODONTIA CARE?

The Delta Dental PPO plus Premier Enhanced Plan provides a $3,000 lifetime orthodontia benefit for adults and children.

DENTAL PROVIDERS

Access to dental providers is outlined below:

Delta Dental Plans

With both the Delta Dental PPO plus Premier Standard and Delta Dental PPO plus Premier Enhanced plans, you may see any dentist, and you save time and money when you see a Delta Dental PPO network dentist because there are no claim forms to file and your dentist accepts the negotiated rate. If you see a non-network dentist, your out-of-pocket costs will be higher. Remember, when you use in-network providers, your benefits are higher, which saves you money.

Delta Dental Online

Delta Dental offers a convenient website that you can access for your dental health care needs. Log in to www.deltadentalins.com to print your ID card or a claim form, find a dentist, read dental health tips, and visit the kid's dental health website.

HOW ARE DENTAL CLAIMS PAID?

Payment by Delta Dental for any single procedure that is a covered service will be made upon completion of the procedure. Payment for care is applied to the calendar year deductible and maximum benefit based on the date of service. After you have satisfied your deductible requirement, Delta Dental will provide payment for covered services at a percentage indicated in the Benefit Summary Chart, up to a maximum for each enrollee in a calendar year.

ORTHODONTIC PAYMENTS

Delta Dental will pay half of its orthodontic payment up front, at the time of banding. The remaining half will be paid one year later. If the treatment time is 12 months or less, Delta Dental's orthodontic payment will be paid as a lump sum at the beginning of the orthodontic treatment. If treatment began prior to the enrollee becoming eligible with Delta Dental, any payments made by a previous dental carrier will be applied to the enrollee's lifetime orthodontic maximum.

DELTA DENTAL ON THE GO: WWW.DELTADENTALINS.COM

Go mobile for convenient services and fast, easy access to your information. Find a dentist, view ID card, manage your account, check benefits, eligibility, check claims status, and claims history.

DENTAL BENEFITS AT A GLANCE	DELTA DENTAL PPO PLUS PREMIER **STANDARD PLAN** IN-NETWORK	DELTA DENTAL PPO PLUS PREMIER **ENHANCED PLAN** IN-NETWORK
Annual Deductibles		
Individual (calendar year)	$50	$25
Maximums		
Individual (calendar year) Orthodontics (lifetime)	Plan pays up to $1,500 N/A	Plan pays up to $2,000 Plan pays up to $3,000
CATEGORY OF SERVICE		
Diagnostic (deductible waived)		
Periodic exams (twice/calendar yr) Bitewing x-rays (twice/calendar yr) Full-mouth x-ray (once/3 yr period)	No charge	No charge
Preventive (deductible waived)		
Prophylaxis/Cleaning (twice/calendar yr) Fluoride treatments (twice/year to age 18) Sealants (to age 18) Space maintainers (to age 14)	No charge	No charge
Basic Restorative		
Fillings	You pay 40% coinsurance	You pay 20% coinsurance
Major Restorative		
Single crowns, inlays, onlays	You pay 40% coinsurance	You pay 20% coinsurance
Endodontics		
Root canal, pulpal therapy	You pay 40% coinsurance	You pay 20% coinsurance
Oral Surgery		
Extraction and other oral surgery incl. pre- and post- operative care	You pay 40% coinsurance	You pay 20% coinsurance
General Anesthesia		
Covered when used in conjunction with covered oral surgical procedures Endodontics Root canal, pulpal therapy	You pay 40% coinsurance	You pay 20% coinsurance
Surgical Periodontics		
Surgical treatment of the gums and supporting structures of the teeth	You pay 40% coinsurance	You pay 20% coinsurance
Non-Surgical Periodontics		
Non-surgical treatment of the gums and supporting structures of the teeth	You pay 40% coinsurance	You pay 20% coinsurance
Prosthodontics		
Procedures for replacement of missing teeth by construction or repair of bridges and partial or complete dentures, implant surgical placement & removal, supported prosthetics, including repair & re-cementation.	You pay 40% coinsurance	You pay 20% coinsurance
Orthodontics (deductible waived)		
For eligible employees, spouses and dependents to age 26 (Subject to lifetime maximum)	No coverage	You pay 50% coinsurance

* *Out-of-network providers are covered at the same percentage level. However, your costs may be higher since benefits for non-network dentists are subject to usual and customary rates. You are responsible for any amount that exceeds the usual and customary amount. Adult fluoride treatments are not covered.*

Plan Rates

MEDICAL, DENTAL AND VISION PLAN PREMIUMS

Our goal is to ensure that our benefits remain affordable to all employees. Children's National pays much of the cost of your medical and dental coverage, and all of the cost of your long-term disability and basic life insurance.

MEDICAL BENEFITS				
BI-WEEKLY PREMIUM COST	**AETNA PPO**	**AETNA HDHP**	**AETNA HMO**	**KAISER HMO**
Employee Only	$51.47	$32.10	$102.20	$79.61
Employee + Spouse/Domestic Partner*	$194.54	$106.43	$311.11	$292.86
Employee + Child(ren)	$176.01	$97.89	$289.53	$272.55
Family	$277.92	$144.88	$408.24	$384.30

DENTAL BENEFITS			
BI-WEEKLY PREMIUM COST	**DELTA DENTAL**	**STANDARD PLAN**	**ENHANCED PLAN**
Employee		$8.75	$21.73
EE+Spouse/Domestic Partner*		$16.25	$42.60
EE+Child(ren)		$14.78	$36.22
Family		$20.30	$57.32

VISION BENEFITS			
BI-WEEKLY PREMIUM COST	**VISION SERVICE PLAN**	**STANDARD PLAN**	**ENHANCED PLAN**
Employee		$2.81	$5.49
EE+Spouse/Domestic Partner*		$4.93	$8.76
EE+Child(ren)		$5.01	$9.08
Family		$8.75	$15.15

***NOTE:** If you are covering non-taxed dependents on the plan, imputed income will apply.

Paid Leave

Children's National offers hospital-sponsored paid leave to afford employees more time off from work and address the need for stronger work life balance.

ANNUAL LEAVE

Eligible employees may accrue vacation beginning on the first day of employment. Vacation accrual is based on staff level and years of service. Vacation hours are accrued based on hours paid up to a maximum of 80 hours per biweekly pay period, excluding overtime. Union members should refer to their contract. Residents/Fellows should consult their program administrator.

SICK LEAVE

All eligible employees accrue at a rate of 12 days, including 7 days of ASSLA, annually[1]. (Accruals are pro-rated for employees who work part-time.) Unused sick leave may be carried over up to a maximum of 1,040 hours; pro-rated to a maximum of 520 hours for part-time employees.

PAID HOLIDAYS

Children's currently recognizes the following 9 days as paid holidays:

New Year's Day
Martin Luther King Day
President's Day
Memorial Day
Independence Day
Labor Day
Veterans Day
Thanksgiving Day
Christmas Day

In addition, eligible employees earn a personal day equivalent to 8 hours, which is added to their vacation bank in July. (CSS and CP&A holiday schedules vary slightly.)

PARENTAL LEAVE

Parental leave is a Children's National provided benefit that offers 100% salary continuance for new parents to use after the birth or adoption of a child. Effective on your date of hire, benefit eligible, non-union and CIR union employees may receive 12 weeks of parental leave for the birth or adoption of a child, and baby bonding.

Non-Exempt Staff

YEARS OF SERVICE	VACATION ACCRUALS	SICK/ASSLA ACCRUAL[1]
0 < 5 years	80 hours	96 hours
5 < 10 years	120 hours	
10 < 15 years	160 hours	
15 or more years	200 hours	

Exempt Staff

YEARS OF SERVICE	VACATION ACCRUALS	SICK/ASSLA ACCRUAL[1]
0 < 10 years	120 hours	96 hours
10 < 15 years	160 hours	
15 or more years	200 hours	

Physician, Faculty, Directors & Above

YEARS OF SERVICE	VACATION ACCRUALS	SICK/ASSLA ACCRUAL[1]
0 < 15 years	160 hours	96 hours
15 or more years	200 hours	

Flexible Spending Accounts (FSA)

HOW FSAs ARE USED

You can use pre-tax dollars to pay for your eligible out-of-pocket costs for health and dependent care. You have two FSA plan options:

- Medical FSA for eligible out-of-pocket health care costs.
- Dependent Care FSA for eligible dependent care expenses.

HOW FSAs WORK

You choose whether you want to contribute to one or both FSAs. It works like this:

1. You decide how much you want to contribute for the calendar year.
2. Your contributions are taken out of your paychecks in equal amounts before taxes each payday.
3. When you incur health care or dependent care expenses, you are reimbursed from your account.

FSAs SAVE YOU MONEY

When you use an FSA to pay for eligible expenses, it's like buying these items "on sale." With savings of 35% or more (depending on your tax bracket), the amount you save can really add up. Log on to **www.payflex.com** to view a list of common eligible expenses and other helpful FSA tools. These tools will help you determine if you should participate in an FSA, and how much you should contribute to cover your eligible out-of-pocket medical and dependent care expenses.

FSA RULES, ESTABLISHED BY THE IRS:

It is important to remember certain IRS rules apply to FSA accounts. FSA accounts are designed as "use it or lose" plans so you want to make sure to carefully estimate what your health care and dependent care expenses will be for the year. The two FSAs are separate. You cannot transfer money from the Medical FSA to the Dependent Care FSA, or vice versa.

The IRS has established rules for FSA administration:

1. For the calendar year 2023, all claims should be incurred between January 1, 2023 and March 15, 2024, (a full 14 1/2 months) to be reimbursed from your 2023 FSA account.
2. You must file all claims by May 15, 2024.
3. You forfeit any money that remains in your FSA after the deadline.

PAYFLEX CARD:

If you elect to enroll in the medical FSA account, you will automatically receive a PayFlex debit card. If you do not wish to utilize it, you do not have to activate it.

ESTIMATE YOUR COSTS CAREFULLY

How can you avoid losing money that remains in your FSA? The answer is simple. Just take the time to carefully estimate what you think your expenses will be for the year.

IMPORTANT REMINDER:

You must re-enroll for your FSA annually during open enrollment. You are not automatically re-enrolled for next year, even if you participated this year.

FSAs

PLAN FEATURE	MEDICAL FSA	DEPENDENT CARE FSA
You can contribute...	Up to $2,850 If you enroll the High Deductible health plan, you are not eligible for the medical FSA, but may enroll in the LFSA.	Up to $5,000 $2,500 limit if married and you and your spouse file separate returns
To pay for...	Health related expenses, such as: · Out-of-pocket medical, prescription, dental or vision expenses not reimbursed by health care plans · Copays, deductibles, and coinsurance · Alternative medical care, such as acupuncture and holistic treatments · Smoking cessation programs · Weight loss programs for individuals diagnosed as obese · Over-the-counter medications, if prescribed by a doctor. For eligible expenses see payflex.com	Out-of-pocket expenses for dependent children under age 13 or disabled dependents of any age, such as: · Daycare centers or in-home care provided by someone who is not your child and who you do not claim as a tax dependent · Pre-school expenses for children not yet in kindergarten or a higher grade · After school programs or summer camps for children under age 13 · Day camp expenses (not overnight)
Qualifying expenses must be...	· Medically necessary · Not reimbursable under the plan · Incurred by you or anyone you claim as a dependent on your tax return	· Necessary so you can work, and if you are married: – Necessary so your spouse can work or attend school full-time, or – Necessary to care for your disabled dependent of any age · Incurred by you
Reimbursement Options	· Direct Deposit: you can have your reimbursements deposited into your bank account. · Debit Card: use the debit card to pay copays.	· Submit your claim and upload receipts online. · You can receive a paper check or direct deposit to your bank account. · You can only receive reimbursement based on the balance in your account.

WE'LL SHOW YOU HOW SIMPLE IT IS TO PAY FOR YOUR ELIGIBLE EXPENSES:

- Use the PayFlex Card®, your account debit card: When you use the PayFlex debit card (if offered), your expense is automatically paid from your FSA.
- Pay yourself back: Pay for eligible expenses with cash, a check or your personal credit card. Then submit a claim to pay yourself back. For speed, have your claims payment deposited directly into your checking or savings account.
- Pay your provider: Use PayFlex's online feature (if offered) to pay your provider directly from your account.

HERE ARE A FEW FSA REMINDERS:

- Save your itemized statements and detailed receipts.
- View the IRS contribution limits and a list of common eligible expense items on the PayFlex member website.
- FSAs have a use-it-or-lose-it rule. This means you'll lose any unused funds at the end of the plan year.
- The run-out period gives you extra time to submit claims to pay yourself back. A run-out period is a timeframe in the new plan year during which you can file claims for expenses incurred in the previous plan year (January 1 - March 15, 2023).

For Your **Income Protection**

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

As an employee of Children's National or a Children's National affiliated organization, you automatically receive basic life and accidental death and dismemberment insurance (AD&D) at no cost to you.

Life insurance provides benefits upon your death for any reason. AD&D insurance provides benefits if you die or suffer a covered loss as the result of an accident.

Basic life and AD&D insurance is based on your staff level, as shown in the chart below.

BASIC LIFE AND AD&D

STAFF LEVEL	COVERAGE	MAXIMUM
Non-exempt staff Exempt management Exempt non-management staff Fellows/Residents	2 x annual base salary	$200,000
Faculty, Directors and above	3 x annual base salary	$600,000

EMPLOYEE PAID LIFE INSURANCE

You must enroll in these benefits within 30 days of your hire date, or during the annual open enrollment period.

Supplemental Employee Life Insurance

You can add to your basic life insurance by purchasing supplemental employee life insurance. Supplemental employee life insurance is available in $10,000 increments up to a maximum benefit of five times your annual earnings or $500,000, whichever is less.

Spousal Life Insurance

If you elect supplemental employee life insurance for yourself, you also may elect life insurance for your spouse. Coverage for your spouse is available in $5,000 increments, up to a maximum benefit of $250,000. The amount of spousal coverage may never exceed 50% of the Supplement Life Insurance in force for you.

Dependent Life Insurance

If you elect supplemental employee life insurance for yourself, you also may elect life insurance for your dependent children under the age of 26. Coverage for your dependent children is available in amounts of $5,000 or $10,000.

Life Insurance Costs

The cost of supplemental life insurance for you and your spouse depends on your age. Your premiums change as your age increases. Life benefits are reduced upon reaching age 65.

WHAT IS EVIDENCE OF INSURABILITY?

Evidence of insurability (EOI) requirements (proof showing you/your dependents are in good health) apply to your supplemental life insurance elections. For new hires, any supplemental life election over the guaranteed issue amount of $100,000 is subject to EOI. For employees who are not newly eligible, EOI is required for any election or increase. For spousal life, any election over the guaranteed issue amount of $50,000 is subject to EOI. For dependents who are not newly eligible, EOI is required for any election or increase. For children, coverage is guaranteed up to the elected amount with no EOI required.

THE HARTFORD, OUR BASIC LIFE AND AD&D INSURANCE VENDOR, ALSO PROVIDES THE FOLLOWING BENEFITS:

Free Will – EstateGuidance Program

This service helps you create a simple legal will quickly and conveniently online, with the support of licensed attorneys if needed. It can save you the time and expense it would take to create a will with a private attorney. Creating your will online is just a few simple steps away:

1. Access The Hartford's EstateGuidance service online at www.EstateGuidance.com/wills .
2. Sign in to the secure site by entering the access code HFD3543 .
3. Follow the instructions and create your will.
4. Download the final will to your computer and print.
5. Obtain signatures and determine if your will should be notarized.

When creating your will, EstateGuidance gives you the option to save a draft of your will for up to six months. Revisions to the will can be made during this period at no cost to you, provided you have not already printed or downloaded your will.

Everest Funeral Planning and Concierge Service

Your basic life insurance policy through The Hartford provides a 24/7 funeral planning assistance from Everest, the first nationwide funeral planning and concierge service. You and your family (spouse/partner and children under age 25) are entitled to:

- 24/7 Advisor Planning Assistance: assistance with funeral planning issues and help creating a personal funeral plan. A Sr. Advisor is assigned to the family to provide 24-hour assistance throughout the funeral process including communicating the Personal Funeral Plan to the funeral home, gathering pricing information and presenting it in an easy-to-read format, negotiating funeral service pricing with local funeral homes and helping the family compare prices of caskets and other products.
- Everest PriceFinder: detailed, local funeral home price comparisons available on demand via the website www.everestfuneral.com.
- Online Funeral Planning Tools that are stored in a secure data warehouse for you.

Call an Everest Advisor at 1-800-913-8318 if you have questions or log into the website **www.everestfuneral.com**, select **Client Log In** and select **Create Your Profile** in the **New to Everest?** box to view services available to you.

TRAVEL ASSISTANCE AND ID THEFT PROTECTION SERVICES

The Hartford's travel assistance and ID theft protection services provides four kinds of services for your business or vacation travels: emergency medical assistance, pre-trip information, emergency personal services, and identity theft protection while traveling. Contact Europ Assistance USA at 1-800-243-6108, and provide Travel Assistance Identification Number GLD-09012.

ESTATE PLANNING

Planning an estate is one of the most important steps anyone can take to help their families. Whether you have some assets to pass on or you have a modest estate, planning lets you gain greater control over your finances and personal affairs.

Estate planning is all about passing on assets, goals and dreams to the people you care about most. Make sure they know what your intentions are and where they can find the documents necessary to carry them out.

FUNERAL PLANNING

While you can't predict life's certain outcome, you can now prepare for it – and give your family the most precious gift you can possibly leave behind.

Your life insurance policy entitles you to expert advice, assistance and services from the first nationwide funeral planning and concierge service – Everest. With Everest, you plan your funeral well ahead of time, making your wishes known electronically and on paper – from the type of service you prefer to funeral home selection and various other choices.

THE HARTFORD

DISABILITY INSURANCE

Long-Term Disability Insurance

As an employee of Children's National or a Children's National affiliated organization, you automatically receive long-term disability insurance at no cost to you. Long-term disability insurance may cover you if your illness or injury continues beyond three months. You are eligible to participate in long-term disability insurance after you have been continuously employed by Children's National for six months.

Benefits are based on your staff level, as shown below:

LONG-TERM DISABILITY

STAFF LEVEL	% OF MONTHLY PAY	MAXIMUM
Non-exempt	60%	$5,000/month
Exempt/ Managers	60%	$5,000/month
Faculty/ Directors Fellows/Residents/ Physicians	70%	$10,000/month

OPTIONAL INCOME PROTECTION BENEFITS

You must enroll in these benefits within 30 days of your hire date, during annual open enrollment for The Hartford or during optional open enrollment for UNUM.

The Hartford Short-Term Disability Income (STD) Plan

Short-term disability has two options: 60% (weekly benefit amount of $2,310) and 50% (weekly benefit amount of $1,950). Benefit becomes effective the first of the month following the date of hire.

UNUM Short-Term Disability Income (STD) Plan

This option replaces up to 60% of your income in the event of a qualified sickness or injury that keeps you from working. The maximum monthly benefit is $5,000; you decide the amount of coverage needed. Your income benefit is payable for three months, less the 14 day waiting period. All monthly benefits are received income tax free to you. You pick the plan that best fits your needs and your budget.

As a new employee, you have two options for enrolling in STD:

- **Apply within your first 30 days of employment**
  - If you apply now and have pre-existing medical conditions, you could be denied for coverage. If your application is denied, you will not be able to apply during the annual open enrollment period.
  - If you don't have pre-existing medical conditions and want to apply now, call 1-877-454-3001. UNUM will review the application and make a decision.
- **Enroll later**
  - If you enroll later, during the annual open enrollment period, your coverage will be approved whether or not you have a pre-existing medical condition.

If you have questions about the UNUM STD coverage, please call 1-877-454-3001.

FINANCIAL SECURITY WHEN YOU NEED IT MOST

Three out of every 10 employees between the ages of 25 and 65 will be out of work for three months or longer due to an accident or illness. Long-term disability insurance can help by continuing a portion of your income during the time you are disabled.

OTHER OPTIONAL INCOME PROTECTION BENEFITS – AVAILABLE DURING BENEFITS OPEN ENROLLMENT PERIOD

You may only enroll in the following pre-tax Optional Income Protection Benefits during the annual Benefits Open Enrollment period.

UNUM – WHOLE LIFE INSURANCE WITH LONG-TERM CARE INSURANCE RIDER

This option provides a fixed premium and level death benefit for life, as well as cash value accumulation within the policy as long as premiums are paid by the due date. Coverage starts as low as $10,000 of death benefit. Coverage also is available for your spouse and children under the age of 25. Benefits are paid as a lump sum and are received income tax free to you. With the long-term care insurance rider, your long-term care insurance will cover you when you are chronically ill. In addition, optional benefits available to your long-term coverage include:

- **Restoration Benefit** – restores 100 percent of the policy's specified amount, death benefit, and cash value.
- **Continuation Benefit** – continues benefits after all monthly amounts under that rider have been exhausted. No death benefit is payable during continuation.
- **Combination Restoration/Continuation** – combines both of the above riders' features, triples the long-term care benefit available.

UNUM – CRITICAL ILLNESS PLAN

This option pays a one-time lump sum amount, determined by the employee, if the employee is diagnosed with any of the following critical illnesses: heart attack, stroke, major organ transplant, permanent paralysis, end stage renal failure, coronary artery bypass, or cancer. A policy is not guaranteed for this coverage; you will be asked limited medical health questions to qualify.

UNUM – ACCIDENT INSURANCE

This option provides flat dollar payments that are not offset by health insurance benefits when an accidental injury occurs on and off the job. The base plan covers a wide range of injuries and accident-related expenses such as hospitalization, physical therapy, transportation and lodging, plus coverage for accidental death and catastrophic accidents that involve the loss of sight, hearing, speech, arms, or legs. An optional Sickness Confinement Rider can be added to the base accident plan that pays a daily hospital confinement sickness benefit ($100 per day for employee and spouse and $75 per day for children) for covered sicknesses if confined as an inpatient to a hospital for at least 20 hours or more.

AFLAC – HOSPITAL PROTECTION

Aflac provides the Hospital Choice Plan, a hospital confinement indemnity plan that pays covered persons a cash benefit, independent of other insurance coverage, for experiencing a confinement for 23 hours or more due to sickness or injury. Aflac will pay $500 - $5,000 when a covered person requires hospital confinement for 23 or more hours for a covered sickness or injury and a room charge is incurred. This benefit is payable once per calendar year, per covered person.

Aflac will also pay a covered person a cash benefit of one hundred dollars ($100) per day when the covered person is hospitalized and transferred to a rehabilitation facility due to a covered sickness or injury. Aflac will pay $100 day when a covered person is confined in a hospital and is transferred to a room in a Rehabilitation Facility for treatment of a covered sickness or injury and a charge is incurred each day for such treatment.

For Your **Retirement**

RETIREMENT PLAN OPTIONS

Planning for retirement is important. That's why Children's National offers a retirement plan to help you save for the future and contributes to your retirement account. You may enroll in a Children's National retirement plan or change your retirement plan contributions at any time during the year by calling Fidelity at 1-888-461-2662, or logging on to Fidelity Net Benefits at www.netbenefits.com/atwork.

401(k) Retirement Plan (all staff)

Your contributions to the 401(k) retirement plan are deducted before taxes and you are immediately 100% vested. After one year of employment, Children's will begin making a 100% matching contribution (based on your contribution) up to 5% of your gross bi-weekly salary. The money that you and Children's contributes invests over time in selected funds with Fidelity Investments. You choose your own investments. Your contributions are limited to $19,500 per IRS regulations. To find out more about the services Fidelity offers to plan participants, log on to www.netbenefits.com/atwork or call Fidelity at 1-888-461-2662.

IMPORTANT NOTE

You can change your retirement plan contributions at any time during the year. Retirement plan contribution changes will take affect the next available pay period after you elect changes.

RETIREMENT SPECIAL CATCH-UP RULES

If you are age 50, or turning 50 in 2023, the IRS allows you to make additional contributions (called "catch-up contributions") over and above the annual limit. If eligible you may contribute an additional $6,500 after you have reached the $19,500 annual limit.

The table below shows you the key features of the 401(k) retirement plan offered at Children's National.

RETIREMENT BENEFITS AT A GLANCE

	401(K) PLAN
When may I enroll?	Immediately following hire date
When am I vested?	100% immediate vesting
How much may I contribute?	$19,500 per year under IRS limit. If you are age 50 or over, or you are turning 50 this year, the catch-up contribution limit is $6,500
Is there a matching contribution by Children's?	After one year of service, Children's National matches your contributions at 100% up to 5% of your gross bi-weekly salary
Can I rollover money from another qualified retirement plan?	Yes
Can I take a loan against my retirement account?	A loan or a hardship withdrawal can be taken if you meet certain criteria

For Your **Living Resources**

We realize you work hard at Children's National, so you deserve benefits that help you balance work and life. Below is a summary of the work/life benefits available to you. You are automatically eligible for these benefits. **Benefits marked in bold are paid by Children's National.**

SUMMARY OF FOR YOUR LIVING RESOURCES BENEFIT PROGRAMS

- **Employee Assistance Program (EAP)**
- Back-up Care Program
- Legal Insurance
- Homeowners and Automotive Coverage
- Pet Insurance
- Identity Theft Protection
- Children's Discount on Hospital Services
- Commuter Benefits—SmartBenefits
- Fitness Centers
- **Educational Assistance**
- Credit Union Membership

EMPLOYEE ASSISTANCE PROGRAM (EAP)

At some point in our lives, each of us faces a problem or situation that is difficult to resolve. When these instances arise, SupportLinc will be there to help. The SupportLinc employee assistance program (EAP) is a confidential resource that helps you deal with life's challenges and the demands that come with balancing home and work. SupportLinc provides confidential, professional referrals and up to six (6) sessions of face-to-face counseling sessions for a wide variety of concerns, such as:

- Anxiety
- Depression
- Marriage and Relationship Problems
- Grief and Loss
- Substance Abuse
- Anger Management
- Stress
- Financial Assistance
- Legal Assistance
- Family Assistance

Care@Work – cnh.care.com
Phone: 1-888-881-LINC (5462)
Web: https://www.supportlinc.com/
Username: cnhs

You have access to the Care@Work benefit, a family care service that can help you find caregivers for your whole family, including your child, parents/grandparents and/or pet. Your Care@Work benefit gives you:

- Free access to Care.com, a database of providers for your family care needs
- Back Up Care which provides vetted and subsidized adult and child care when your regular care is not available.

For more detailed information regarding Care@Work, please visit the CN Benefits intranet page under Other Benefits and Discounts.

To activate your benefit, go to cnh.care.com and select "Enroll Now" or call 855.781.1303 or email careteam@care.com for assistance.

OPTIONAL INSURANCE PROTECTION AND SERVICES

You may enroll in the following benefits at any time during the year.

LegalEase – Legal Insurance

The LegalEase LegalGuard Family Legal Protection Plan provides you access to professional legal consultation and representation at affordable group rates. If you need legal assistance, simply call the Member Service Center and a Specialist will help you get in touch with the right plan attorney for your legal matter.

Travelers Insurance – Homeowners and Automotive Insurance

Travelers Insurance offers special discounted rates and quality coverage for auto, home, condo and other personal insurance coverage. This option offers you a group discount with the added convenience of payroll deduction for all your auto, home/condo and renter insurance needs.

PetFirst – Pet Insurance

PetFirst insurance provides comprehensive coverage for accidents, illnesses and routine care. Save up to 90% on your pet's veterinary bills after a $50 per incident deductible. Reimbursement issued within two weeks. Important features include: use of any veterinarian nationwide, easy online policy management to track claims processing, and quick and easy administration. You pay for this benefit via credit card or electronic debit from your bank account.

AllClear ID – Identity Theft Protection

AllClear ID provides advanced and effective identity theft protection to help safeguard your personal information. AllClear ID Protection gives you the ability to respond to threats to your identity faster by delivering secure phone alerts that enables you to take immediate action if you suspect your identity is at risk. You pay for this benefit via credit card.

How to Enroll in Optional Insurance Protection and Services

To enroll or find out more about the optional income protection and services benefits listed above, including premiums and services, call the following:

Legal: LegalGuard 1-888-416-4313

Home & Auto: Traveler's 1-888-695-4640

ID Protection: AllClear ID 1-866-979-2595

Pet: PetFirst 1-866-937-7387
(*Mention Children's National Legacy Group.*)

DISCOUNT ON CHILDREN'S NATIONAL HOSPITAL SERVICES

Receive the very best in medical advice and care for your children and come to Children's National when your child needs medical attention. Employees of Children's National or a Children's National affiliated organization receive a discount on their share of the cost of hospital services for their child(ren) at Children's National.

- **If you have insurance and services are billed to insurance** – You are eligible for a 50% discount on any remaining balance for hospital services billed to insurance for your children at Children's National (after applicable copays and deductibles have been paid). Only coinsurance, non-covered, or self-pay services are eligible for the discount**. For example:** If a bill for your child's services at the hospital is a total of $1,000 and your insurance covers $800, the balance you owe (as an employee) could be reduced from $200 to $100.

If you bring your children to Children's National, here's what you need to do:

- Identify yourself as a Children's National employee when your child receives care
- Pay your copay to the physician's office
- File the claim with your insurance company
- After receiving your bill, call Children's National Billing Customer Service (301-572-3542 or 1-800-787-0021) to receive your discount.
- If at the main campus, take your bill to the Billing Office, 1st floor, room 1820.

If you do not have insurance or services are not covered by insurance – You are eligible for a 65% discount on services for your children at Children's National that are not covered by insurance OR will not be billed to insurance. Identify yourself as an employee at the time of service, indicate that you are uninsured or are seeking services not covered by your insurance. After receiving your bill, call 301-572-3542, Children's Billing Customer Service to receive your discount.

COMMUTER BENEFITS – SMARTBENEFITS®

If you take public transportation to commute to and from work, the SmartBenefits® and SmarTrip® program may be for you. This commuter benefit program allows you to use pre-tax dollars to pay for your commute to work.

Additional information about the SmartTrip® card can be found at Washington Metropolitan Area Transit Authority (WMATA's) website at **www.wmata.com** (click on the SmarTrip® link). To enroll, complete and submit (to the Benefits Office) the SmartBenefits enrollment form available on the Benefits intranet page.

GLOBAL FIT MEMBERSHIPS

Enroll with Global Fit and your membership includes a host of discounts and resources on living a healthier lifestyle through diet and exercise. The Global Fit membership provides discounts on local gym memberships, information on getting fit, tips on eating healthy, and much more. To enroll, contact GlobalFit at 1-800-294-1500 or **www.globalfite.com/cnmc.**

TRINITY UNIVERSITY FITNESS CENTER

Trinity University offers discounted memberships to employees of Children's National and Children's National affiliated organizations. The discounted membership fee is $150 for a quarterly membership. The membership includes full use of all of the facilities including the basketball court, tennis courts, pool, spa, walking track, and fitness area, and majority of classes. For more information or to enroll, go to the fitness center or call 202-884-9092. For club hours and address visit **http://www.trinitydc.edu/trinity-center/contact-information/**

WASHINGTON SPORTS CLUBS (TOWN SPORTS INTERNATIONAL)

Employees of Children's National and Children's National affiliated organizations, and their spouses and their spouses, domestic partners and children age 16 or older are eligible for a discount on the one-year Passport Membership. The Passport Membership provides full membership privileges to all club locations at all times, all group exercise classes and club amenities. There are 19 locations in the D.C., Maryland and Virginia area. Payroll deduction is available. **To enroll, contact Quenten Fletcher. Call 504.432.5385 or email quenten.fletcher@tsiclubs.com.** For club locations and hours go to www.mysportsclubs.com. There is a $49 new enrollment fee to activate swipe card.

EDUCATIONAL ASSISTANCE

At Children's National, we encourage our employees to further their education and their careers. After six months of employment, employees are eligible to receive educational assistance. Full-time, non-union employees are eligible to receive up to $1,200 per fiscal year (July 1 – June 30). Part-time, non-union, benefit eligible employees are eligible to receive up to $600 per fiscal year. Educational assistance benefits may be used to obtain a Certification, Associates, Bachelor's, and Master's degrees. There is no benefit for PhD degrees.

To apply for educational assistance, you must submit a completed Educational Assistance application, course description(s) and tuition/fee schedule to Human Resources three weeks prior to class start date. Educational Assistance applications are on the Benefits intranet page.

Union members should consult the collective bargaining agreement for details on available tuition benefits.

NURSING TUITION ASSISTANCE BENEFITS

If you are a regular, full-time or part-time benefits-eligible RN in the DCNA union at Children's National, or who reports through Nursing, you have an additional tuition assistance program available to you. Nursing pays for the costs of formal education courses at accredited colleges or universities. The courses must be related to your job or related to a health care career or a requirement of a health care career program. You are eligible for this tuition assistance after successfully completing six months of employment. You must submit tuition assistance applications to the Nursing Staff Development Department. Benefit is subject to availability of funds.

After you have completed your courses, you are required to remain employed by Children's National in at least a part-time capacity for a minimum of six months following completion of the course(s). Otherwise, you will be required to repay any assistance received.

Also, if you fail to successfully complete a course (with a grade of "C" or better) or end employment prior to completing a course(s), you are required to repay any assistance received. You are not required to repay assistance received if you are involuntarily terminated from employment with Children's National.

CREDIT UNION MEMBERSHIP

Employees may join the SECU Credit Union (www.secumd.org) to receive free checking, online banking, bill payment and other services. Employees may obtain a SECU Credit Union application from the main Human Resources office.

NURSING TUITION ASSISTANCE BENEFITS

Full-time eligible RNs pursing a BSN degree are eligible to receive tuition reimbursement for two courses per semester, or six courses per year, at the out of state tuition rate charged by the University of Maryland.

Part-time eligible RNs pursing a BSN degree are eligible to receive tuition reimbursement for one courses per semester, or three courses per year, at the out of state tuition rate charged by the University of Maryland.

Frequently Asked Questions

NEW HIRE ENROLLMENT

When do I need to enroll if I am a new hire?

You must enroll in medical, dental, vision, flexible spending accounts, short-term disability and supplemental life insurance within 30 days of your hire date.

How do I enroll?

Go to https://bearresourceshr.cnmc.org or call the HR Call Center at 301-830-7640, Monday through Friday, from 7 am until 5 pm (EST). If you enroll online, you will need your username and password. See page 5 (How to Enroll) for detailed instructions.

When will my benefits start?

Enrollment is effective on the first day of the month, if you enroll within 30 days of your hire date. If your hire date is the first of the month, coverage begins on the same day, if you enroll within 30 days of your hire date. STD Benefits are effective based on UNUM's approval date.

What if I don't enroll in medical, dental, vision or flexible spending plans?

You will not have coverage in these plans. You will be enrolled in Children's National paid basic life, AD&D and long-term disability insurance.

When do I receive my insurance cards?

You should receive medical and dental cards within three weeks of enrolling. You can print temporary ID cards from the Aetna and Delta Dental websites. ID card is available for vision coverage but not required. You may obtain a vision ID card by calling 800-877-7195.

OPEN ENROLLMENT

Do I need to re-enroll for 2023?

No, if you want medical, dental, or vision benefits to remain the same for 2023, you do not have to re-enroll. You must re-enroll in the flexible spending accounts (FSA) each year if you wish to participate during the upcoming year. You must re-elect your HSA payroll contribution if you are in the High Deductible Health plan by October 28, 2022.

What if I don't re-enroll in the dependent care or medical flexible spending account (FSA) plans?

You will not have coverage in the FSA for 2023.

When will my open enrollment changes be effective?

If enrolling or re-enrolling during open enrollment, coverage is effective on January 1, 2023.

Up to what age can I cover my child?

You may cover dependent children on the medical, dental, and vision plans up to their 26th birthday.

When do I receive my insurance cards?

- If enrolling for the first time during open enrollment, you should receive your medical and dental cards by the end of December.
- If you did not make any changes, your current medical and dental cards are still effective.

CHANGES DURING THE YEAR

What if I want to change coverage?

The IRS permits changes to coverage only during open enrollment or within 30 days of certain qualifying events (ex. marriage, birth, adoption of a child, etc.).

I am getting married in August. Can I add my future spouse now?

- You must add your spouse to medical, dental, and vision plans within 30 days of your marriage. Call the HR Call Center, at 301-830-7640, to make this change.
- If you do not enroll your spouse within 30 days, you must wait until the next Open Enrollment.

I am having a baby. Is my newborn covered automatically?

No. You must add your newborn to your Children's National coverage within 30 days of birth. Call the HR Call Center, at 301-830-7640, to make this change.

My spouse will start a new job in June. Should we enroll now?

- If you are covered by your spouse's plan and coverage ends when your spouse terminates employment or loses eligibility, you are eligible to enroll in Children's National medical, dental, and vision plans within 30 days of the event.
- Coverage under the medical, dental, and vision plans is effective on the date the other coverage ends. You must provide proof of your loss of coverage.

What if I have changes during the year?

Call the HR Call Center, at 301-830-7640, Monday through Friday, from 7 am until 5 pm (EST) within 30 days of the qualified life event for assistance with your enrollment and eligibility questions or changes.

MEDICAL

How do I find an Aetna doctor?

The most current information on doctors that participate in the health plans administered by Aetna is available at www.aetna.com. Click on "Find a Doctor" and choose Aetna Choice POS II or Aetna Standard Plan under select a plan, then "OPEN ACCESS" or "HMO" under Type of Plan.

Does my family have to choose the same primary care provider (PCP)?

No, each covered family member may select his or her own PCP.

How much will I have to pay for labs if I select one of the PPO plans?

Any preventive lab work sent via LabOne to a Quest Lab will be considered in-network and paid at 100% under the Aetna PPO health plans.

Who do I contact for medical claims information or problems?

Aetna Customer Service at 1-800-570-6874 or log on to www.aetna.com. Create a login and password for Aetna Navigator.

How do I find medical network providers?

You have two options:

- Go online to www.aetna.com. Click on "Find a Provider," and select "Plan type: Aetna Choice POS II (Open Access)."
- Call Aetna Customer Service at 1-800-570-6874.

How can I access Teladoc?

Print your Teladoc ID card and set up your account at Teladoc.com/Aetna (you will need your Aetna ID card to register).

To request a consult with a Teladoc doctor, visit Teladoc.com/Aetna or call 1-855-Teladoc (835-2362).

DENTAL

Do any of the dental plans provide orthodontia benefits for adults?

The Delta Dental Plus Premier Enhanced option offers adult orthodontia benefits.

Who do I contact for dental claims information or problems?

Delta Dental Customer Service at 800-932-0783.

How do I find dental network providers?

Contact Delta Dental Customer Service or log on to www.deltadentalins.com.

VISION

Who do I contact for vision claims information or problems?

Vision Service Plan (VSP) Customer Service at 1-800-877-7195.

How do I find vision network providers?

Contact VSP Customer Service or log on to www.vsp.com.

PRESCRIPTIONS

What is the difference between a generic medication and a brand name or formulary drug?

Both generics and brand-name drugs have the same active ingredients. A generic is a less expensive duplicate version of the brand-name. It can be less expensive because the pharmaceutical company that led the research and development of the original brand-name drug charged more for that drug during the period of time it was protected from competition. This higher charge resulted in a profit for them and offset the development costs. The company producing the generic drug is charging for the cost of the ingredients and their production expenses.

How do I know the generic is effective and safe?

The Food and Drug Administration (FDA) oversees the manufacturing of the generic drug to make sure it's the same strength and purity as the brand-name drug. The FDA requires that the generic drug be exactly the same in all aspects including having the same active ingredient, same dose and strength, absorbed the same by the person taking it, as well as being safe and effective.

How can I find out how much a drug will cost?

If you are enrolled in an Aetna plan and have Internet access, you can use the "Check Drug Cost Tool" on your secure member website to find out your estimated medication costs. Log in to www.caremark.com and click on "Check Drug Costs".

From there, enter the name of your prescription and your dose. The tool will also show you how much you could save by using Aetna's mail order pharmacy. If you do not have access to the Internet, you can always call Member Services at 1-877-232-8129.

How do I use the CVS/Caremark mail order pharmacy?

You can place orders or obtain mail order forms through the CVS/Caremark website at www.caremark.com.

STEP THERAPY/GENERIC COPAY INCENTIVE

What if I can't take the generic drug? What if I can't take the preferred drug in this new step therapy?

If your physician confirms that you are not able to take either the generic or the preferred drug, your doctor can complete a waiver form. This form will be sent to CVS/Caremark for review and approval. If your request is approved, you will pay only the copay for the prescription.

Will Step Therapy apply to all medications or apply only to targeted conditions or diseases?

Step Therapy only applies to targeted medications for certain conditions and diseases.

What if I already have a prescription for a maintenance medication and I'm not scheduled to go back to my physician for several months for a refill? How and when can I take advantage of Step Therapy or the Generic Copay Incentive?

You would have to contact your physician to obtain a new prescription for your maintenance medication prior to your refill date to take advantage of Step Therapy. You can take advantage of the Generic Copay Incentive if you are taking a generic maintenance medication or you are able to make the switch to a generic maintenance medication.

Can I go to any pharmacy to get my prescription filled?

Yes, even with the generic choice option and step therapy, you can go to any in-network pharmacy to get your prescription filled. As a reminder, the mandatory mail order program requires maintenance medications to be filled through mail order or picked up at a CVS pharmacy. Be sure to check the list of pharmacies in the CVS/Caremark network so that you are choosing a pharmacy where you, and Children's National, pay the least cost.

Can I use mail order with Step Therapy and the Generic Copay Incentive?

Yes, CVS/Caremark mail order service is a great way to fill your prescription for maintenance medications. Maintenance medications are those you take on a frequent basis to help you control a medical condition such as high blood pressure, migraine headaches or asthma.

FLEXIBLE SPENDING ACCOUNTS (FSA)

When can I use the pre-tax money I put in my Medical Spending FSA Account?

You will have access to your total annual election on the first of the month after you enroll. This means that you can spend up to your annual election at any time during the year, regardless of whether the money has yet been deducted from your paycheck.

When can I use the pre-tax money I put in my Dependent Care FSA Account?

You will have access to your dependent care account funds as they accrue throughout the year.

HEALTH SAVINGS ACCOUNT (HSA)

Can I enroll in the Health Savings Account if I am not in a Children's medical plan?

You must be in a High Deductible Health Plan (HDHP) to take advantage of HSAs.

How much can I contribute to a Health Savings Account in 2023?

- $3,850 for employee only coverage
- $7,750 for family coverage (or employee + spouse/domestic partner or employee + child(ren)
- You can elect an additional $1,000 in catch-up contributions each year if you are 55 or older and enrolled in a High Deductible Health Plan.

What happens if I don't use all of the money in the HSA by the end of the calendar year?

- The unused balance in an HSA automatically rolls over year after year.
- You won't lose your money if you don't spend it within the year.
- You must re-elect your HSA payroll contribution each year during open enrollment to participate for the next year.

Can I use my HSA for other expenses?

Any amounts used for purposes other than to pay for "qualified medical expenses" are considered as additional income and are subject to an additional 20% tax penalty. Examples:

- Medical expenses that are not considered "qualified medical expenses" under federal tax law (e.g., cosmetic surgery).
- Other types of health insurance unless specifically described above.
- Medicare insurance premiums.
- Expenses that are not medical or health-related.

Once you turn age 65, you can use your account to pay for non-medical expenses without the 20% tax penalty, but the amount withdrawn will be taxable as income. Individuals under age 65 who use their accounts for non-medical expenses must pay income tax and a 20% penalty on the amount withdrawn.

OTHER BENEFITS

Can I change my retirement contributions at any time?

Yes, you can change your 401(k) contributions at any time during the year by calling Fidelity Net Benefits at 1-888-461-2662 or logging on to www.netbenefits.com/atwork. It may take up to two paychecks for the changes to be reflected.

When do my benefits end if my employment ends?

Benefits end on your last day of employment. You will have the opportunity to continue health benefits through COBRA.

Legal Notices

IMPORTANT NOTICE TO EMPLOYEES FROM CHILDREN'S NATIONAL ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Children's National medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2023. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2023 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Children's National and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

REMEMBER:

Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Children's National Hospital
Human Resources Department
Employee Benefits Office
1 Inventa Place, 5th Floor
Silver Spring, MD 20910
301-830-7640

Notice of Creditable Coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Children's National prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2023. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Children's National plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Children's National coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Children's National plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Children's National and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Children's National coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

As you know, if you have declined enrollment in Children's National's medical plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Children's National will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Children's National group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another medical plan.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 301-830-7640.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 301-830-7640.

CHIP/MEDICAID NOTICE

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Some states offer assistance paying your employer health plan premiums. Visit the Benefits intranet site for a complete list as of July 31, 2022. To see if any other states have added a premium assistance program since January 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

CHILDREN'S NATIONAL HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Children's National health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan – whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Bear PPO, Bear HSA, Bear HMO, Kaiser HMO, Delta Dental Enhanced, Delta Dental Standard, VSP Standard, VSP Signature, Healthcare FSA and Dependent care FSA. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Children's National as an employer – that's the way the HIPAA rules work. Different policies may apply to other Children's National programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with Children's National

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Children's National for plan administration purposes.

Children's National may need your health information to administer benefits under the Plan. Children's National agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits, payroll, and/or finance staff are the only Children's National employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Children's National, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Children's National, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Children's National information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Children's National cannot and will not use health information obtained from the Plan for any employment-related actions. However, health

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises

Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

information collected by Children's National from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out-of-pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on October 1, 2022. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice by either email or the notices *will be mailed to your home address.*

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint:

Children's National Hospital
Human Resources Department
Employee Benefits Office
1 Inventa Place, 5th Floor
Silver Spring, MD 20910
301-830-7640

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact the HR Call Center at 301-830-7640.

PROVIDER-CHOICE RIGHTS NOTICE

The Kaiser HMO generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 1-800-464-4000 or kp.org/searchdoctors

For children, you may designate a pediatrician as the primary care provider.

WELLNESS PROGRAM

HIPAA Notice of Reasonable Alternative Standards (for Health-Contingent Wellness Programs)

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the HR Call Center at 301-830-7640 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE REGARDING WELLNESS PROGRAM

Children's National wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which may include a blood test inclusive of cholesterol, glucose, blood sugars, metabolic panels, etc. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of $150 for completion. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive *the incentive.*

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes . If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the HR Call Center at 301-830-7640.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching and disease management programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Children's National may use aggregate information it collects to design a program based on identified health risks in the workplace, Children's National wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are a registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the HR Call Center at 301-830-7640.

NO SURPRISES ACT NOTICE

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing.**" This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact U.S. Department of Health and Human Services beginning January 1, 2023 at 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

NONDISCRIMINATION STATEMENT

Children's National complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

COBRA CONTINUATION COVERAGE GENERAL NOTICE

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to you Human Resource representative – for additional information please contact the HR Call Center at 301-830-7640.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

HR Call Center at 301-830-7640

INFORMATION ABOUT YOUR DEPENDENT CARE BENEFITS

Working families have some options to help with the cost of their dependent care expenses. Below is a brief overview of the DCAP benefits and the dependent care tax credit. As each individual's situation is different, you may wish to consult with your tax advisor to determine whether the DCAP or the tax credit is a better option.

Dependent care tax credit

The dependent care credit offsets the costs associated with dependent daycare care expenses. For the 2021 tax year, the dependent care tax credit was significantly expanded.

Specifically, the credit is fully refundable and the maximum credit percentage increases to 50% (from 35%). The credit percentage gradually phases down to 20% for individuals with adjusted gross income (AGI) between $125,000 (currently $15,000) and $183,000, and completely phases out for individuals with AGI in excess of $438,000. The amount of dependent care expenses eligible for the credit increase to $8,000 (from $3,000) for one qualifying individual and $16,000 (from $6,000) for two or more qualifying individuals (such that the maximum credits are worth $4,000 and $8,000 based on the 50% maximum credit percentage).

If your family qualifies, the amount of the tax credit you receive directly reduces your taxes, dollar for dollar. For example, a $1,000 tax credit decreases your tax bill by $1,000.

Dependent Care Assistance Program (DCAP)

Under a DCAP (sometimes referred to as a Dependent Care FSA), you set aside funds from your paycheck on a "pre-tax" basis in your own account. This means the funds you elect are taken out of your paycheck before taxes are taken. More details on the DCAP are in the SPD for [Name of Plan].

At the end of the tax year, you will receive a Form W-2 that will reflect a reduction in your taxable income equal to the DCAP and any other pre-tax deductions.

You need to choose one or the other

You cannot claim a tax credit for the same expenses on your income tax return for which you are reimbursed under the DCAP. Work with your tax advisor to determine which is the better option for your particular situation.

OUTBREAK PERIOD NOTICE

Timing Extensions Expiring For HIPAA Special Enrollment Events, COBRA Coverage and ERISA Claim and Appeals

The U.S. Department of Labor and IRS announced temporary extensions of certain plan deadlines during the COVID-19 pandemic. Under these extensions, plan participants and dependents were given extra time to make HIPAA Special Enrollment election changes, file ERISA claims and appeals, receive notifications about COBRA elections, and make COBRA premium payments.

This temporary extension became effective on March 1, 2020 and created individual extension deadlines.

What this means for you and your family

During the period that began March 1, 2020 to present, individual timing extensions can only be extended for a maximum of 12 months. If the original deadline would have been on or after March 1, 2020, your new deadline will now be one-year from your original deadline. For example, if you would have been required to notify the plan of a HIPAA Special Enrollment event (i.e., the birth of a child) by July 1, 2020, your deadline to request an election change under the HIPAA rules will now be June 30, 2023.

Your deadline could end sooner than one year once the National Emergency declaration ends. At the time of this notice, the National Emergency declaration remains ongoing. However, the extensions described here will only last for the shorter of the following two periods: one year from your original deadline, or the period between your deadline (if after 3/1/20) and 60 days following the end of the National Emergency declaration.

If you delayed any of the following due to your timing extension, you should act quickly or you may lose your ability to exercise your rights under the plan for:

- Requesting enrollment under the plan due to a HIPAA Special Enrollment event;
- Filing an ERISA claim or appeal; or
- Enrolling in or making premium payment(s) for your COBRA continuation coverage

If you did not experience a HIPAA Special Enrollment or COBRA qualifying event, or did not have the need to file an ERISA claim or appeal, you do noFt need to take any action.

Questions?

For more information, contact the HR Call center at 301-830-7640.

BENEFITS RESOURCES

WHO TO CONTACT	PURPOSE
HR Call Center 301-830-7640, 7am – 5pm, Monday – Friday https://bearresourceshr.cnmc.org Benefits@ChildrensNational.org	· To enroll in benefits or add/drop dependents from coverage · To report a life event (marriage/divorce, birth/adoption, spouse gains/losses coverage or court-ordered) · To reset your password or login call the HELPDESK at 202-476-4357
Aetna Plans Bear Advantage PPO Bear High Deductible Health Plan with HSA Bear Select HMO 1-800-570-6874 www.aetna.com	· For ID cards, plan benefits/services, claims payments, and prescription questions · To find an in-network provider · For Pre-certification 1-888-632-3862 · Health Savings Account: 1-800-594-9371, option 2
Kaiser Permanente HMO 301-468-6000 or 1-800-777-7902 www.kp.org	· For ID cards, plan benefits/services, claims payments, and prescription questions
CVS/Caremark 1-877-232-8129 www.caremark.com	· Prescription benefit questions · Retail network pharmacy questions · Mail Service pharmacy · Maintenance Choice
Flexible Spending Accounts 1-844-729-3539 www.payflex.com	· For Dependent care and Medical FSA reimbursements and services · For eligible expenses and other plan questions
Delta Dental PPO 1-800-932-0783 www.deltadentalins.com	· For ID cards, plan benefits/services, claims and provider questions · To find a Delta Dental provider
Vision Service Plan (VSP) 1-800-877-7195 www.vsp.com	· For Vision benefit plan questions · To find a VSP provider · To file out-of-network reimbursements
Employee Assistance Plan Backup Care 1-855-213-2933 www.mylifevalues.com (user ID: children, password: EAP)	· For employee assistance benefits, work-life benefits or to make back up care arrangements
Fidelity Investments 1-888-461-2662 www.netbenefits.com/atwork	· 401(k) retirement information · Rollovers · Loans and withdrawals

WHO TO CONTACT	PURPOSE
The Hartford 1-800-752-9713 www.thehartford.com	· For Group Life, AD&D, Supplemental Life claims · For Group Long-Term Disability claims
The Hartford/Leave Management 1-888-899-1915 www.thehartford.com	· For FMLA leave · For Short-Term disability claims. · ADAAA
UNUM/Willard-Block: 1-877-454-3001 ID Protection: All Clear 1-866-979-2595 Home & Auto: Traveler's 1-888-695-4640 Legal: LegalGuard 1-888-416-4313 Pet: PetFirst: 1-866-937-7387	· To enroll or make changes to Identity Theft protection, Homeowners & Automotive insurance, Legal Insurance, and Pet Insurance
Aflac Customer Service 877-384-5939 www.aflac.com/childrensnational	· Individual Hospital Confinement Indemnity Insurance
Global Fit 1-800-294-1500 www.globalfit.com/cnmc	· To receive fitness center discount information · To join a fitness center
Trinity Fitness Center 202-884-9092 www.trinitydc.edu/trinity-center/facilities.html	· To join the fitness center
Washington Sports Clubs 504.432.5385 quenten.fletcher@tsiclubs.com www.mysportsclubs.com	· To receive fitness center membership information · To join a fitness center

This Guide offers details of your benefit options with Children's National – details you can use to make informed benefit decisions. We hope you value and appreciate these benefits and use them when you need to. For more complete information on any one of these benefit plans, please refer to the Summary Plan Descriptions (SPD) located on the Children's National Intranet.

Children's National

111 Michigan Ave NW
Washington, DC 20010-2970

www.ChildrensNational.org

Children's National is a member of the Children's Miracle Network.

Children's National does not discriminate on any grounds prohibited by applicable law, including race, color, religion, age, sex, national origin or ancestry, sexual orientation, marital status, status as a disabled or Vietnam veteran or as a qualified disabled individual.

Revised 09/2022